Residential Habilitation Standards

Revised June 18, 2020

Introduction

The Vision of the South Carolina Department of Disabilities and Special Needs (DDSN) is: To provide the best in services to assist persons with disabilities and their families in South Carolina.

DDSN's Mission is to: Assist people with disabilities and their families through choice in meeting needs, pursuing possibilities and achieving life goals, and minimize the occurrence and reduce the severity of disabilities through prevention.

DDSN values:

- The health, safety and well-being of each person
- Dignity and respect for each person
- Individual and family participation
- Choice, control and responsibility
- Relationships with family, friends and community connections
- Personal growth and accomplishments

The Home and Community-Based Services (HCBS) Rule issued by the Centers for Medicare and Medicaid Services (CMS) requires that all home and community-based settings meet certain requirements. The DDSN Residential Habilitation Standards reflect the agency's values and incorporate the HCBS Rule requirements which are listed below:

- The setting is integrated in and supports full access to the greater community.
- The setting is selected by the individual from among setting options.
- The setting is physically accessible.
- Individual rights of privacy, dignity and respect, and freedom from coercion and restraint are ensured.
- Autonomy and independence in making life choices are optimized.
- Choice regarding services and who provides them is facilitated.
- The individual has a lease or other legally enforceable agreement providing similar protections.
- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit.
- The individual controls his/her own schedule including access to food at any time.
- The individual can have visitors at any time.

Any modification to these additional requirements for provider-owned or controlled home and community-based residential settings must be supported by a specific assessed need, justified in the person-centered plan and reviewed by the human rights committee. Positive interventions and supports must be tried before the modification, use of less intrusive methods documented and data collected to review the modification. The modification must be time limited, include informed consent and cause no harm.

Effective providers of Residential Habilitation Services structure their systems of services and supports to ensure that people who receive services experience these values throughout the daily fabric of their lives.

Residential Habilitation services demonstrate due regard for the health, safety and well-being of each person when they:

- Meet or exceed applicable federal, state and local fire, health and safety regulations, policies and procedures.

- Carefully consider each person's vulnerability to abuse, neglect or exploitation and regularly review the effectiveness of efforts to provide appropriate protection in consultation with the person.

- Regularly review each person's health status and ensure that health care is comprehensive and ongoing.

- Ensure that the preferences and desires of the person are the focus of all planning and the person is included in all planning.

- Develop creative ways to meet health and safety needs using natural supports as well as paid supports while recognizing the importance of the values of relationships, participation, choice, empowerment, responsibility and control.

Dignity and respect - Participation, choice, control and responsibility

Despite the presence of disabilities, people retain the same human, civil and constitutional rights as any citizen. People receiving Residential Habilitation Services rely on their services for support and encouragement to grow and develop, to gain autonomy, become self-governing and pursue their own interests and goals. Effective Residential Habilitation programs take positive steps to protect and promote the dignity, privacy, legal rights, autonomy and individuality of each person who receives services.

Respectful service providers carefully listen to what each individual expresses, using creative methods if necessary, to learn about their desires, plans and preferences.

Community connections - Relationships with family and friends

People should be present in the community and actively participate using the same resources and doing the same activities as other citizens.

Residential Habilitation Services promote inclusion when they:

- Support people to live in residential areas which are convenient to a range of places to shop, bank, eat, worship, learn, make friends and participate in community life.

- Support people to use available transportation to get where they need and want to go.

- Support and encourage people to participate in a variety of activities and to try new places and activities outside their homes and service settings.

- Support and encourage people to meet others, participate with other members of the community (not just paid staff) in shared activities and join associations of interest that offer membership.

- Support and encourage people to give back to the community in meaningful ways through volunteer opportunities.

Relationships

Friends and family offer people essential support and protection. They provide continuity throughout life, act as a safety net, and open the way to new opportunities and experiences.

Many people with developmental disabilities rely on Residential Habilitation Services for assistance in maintaining relationships with family and friends. Some also need help to meet new people and make new friends.

Residential programs support relationships when they:

- Identify the people who are important to each person who receives services and provide them with assistance to re-establish or maintain contact with them.
- Recognize that family members are very important to some people and work to negotiate any conflicts that arise between the program and family members in ways that protect relationships.
- Encourage people to reach out to other people. Some people who have been socially isolated need opportunity, guidance and coaching to assist them in making friends.
- Welcome the people a person with a disability chooses as friends. If the person’s choice of a friend conflicts with the person’s health and safety interests, respectfully negotiating these situations strengthen the quality of staff relationships with the people they serve.

Council on Quality and Leadership

Definitions

Residential Habilitation Services include the care, skills training and supervision provided to individuals in a non-institutional setting. The degree and type of care, supervision, skills training and support of individuals will be based on the plan and the person's needs. Services include assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Residential Habilitation can be provided in a variety of settings.

Intensive Behavioral Intervention

When services that use current, empirically-validated practices to identify causes (i.e., function) of, interventions to prevent, replace and appropriately react to problem behavior are employed as part of the care, supervision, and skills training provided to those who receive Residential Habilitation, those services are known as "Intensive Behavioral Intervention".

Intensive Behavioral Intervention includes:

- Conducting behavioral assessment (i.e., functional assessment and/or analysis) including indirect and direct assessment; observation of the person; interview of the person, key staff, family, etc.; determination of personal preferences or interests; development of objective definitions; collection of direct assessment objective data (i.e., A-B-C data); the analysis and summary of the collected data, and development of a competing behavior pathways diagram.

- Developing specific interventions based on the behavioral assessment that focuses on the replacement of the problem behavior with appropriate behavior that serves the same purpose (i.e., function) and the prevention of the problem behavior.

- Securing appropriate approvals and consents.

- Training others to accurately implement the interventions developed to address the problem behavior.

- Monitoring, through the use of line graphs and observation-based fidelity checks, the implementation and the effectiveness of the interventions to ensure the occurrences of problem behaviors are decreasing and the occurrences of replacement behavior(s) are increasing,

- Ensuring ineffective interventions are modified when needed.

Community Training Home-I Model (Foster Care)

In the Community Training Home-I Model, personalized care, supervision and individualized training are provided, in accordance with a service plan, to a maximum of two (2) people living in a support provider's home where they essentially become one of the family. Support providers are qualified and trained private citizens. CTH-I homes meet Office of State Fire Marshal Foster Home Regulations.

Community Training Home-II Model

The Community Training Home-II Model offers the opportunity to live in a homelike environment in the community under the supervision of qualified and trained staff. Care, skills training and supervision are provided according to individualized needs as reflected in the service plan. No more than four (4) people live in each residence.

Community Integrated Residential Services (CIRS)

This model was created to promote personal development and independence in people with disabilities by creating a customized transition from 24-hour supervised living to a semi-independent living arrangement. Participants are

responsible for selecting support providers, house mates and housing. A lease support agreement connects participants with landlords and provides an extra level of support which might be needed to facilitate a positive landlord/tenant relationship. CLOUD homes located in one and two family dwellings, as well as townhouses, shall meet International Residential Code (IRC) standards. CLOUD residential models are not care facilities.

Supervised Living Model-II

This model is for people who need intermittent supervision and supports. They can handle most daily activities independently but may need periodic advice, support and supervision. It is typically offered in an apartment setting that has staff available on-site or in a location from which they may get to the site within 15 minutes of being called, 24 hours daily.

Supported Living Model-I

This model is similar to the Supervised Living Model-II; however, people generally require only occasional support. It is offered in an apartment or house setting and staff are available 24 hours a day by phone.

Community Residential Care Facility (CRCF)

This model, like the Community Training Home-II Model, offers the opportunity to live in the community in a homelike environment under the supervision of qualified, trained caregivers. Care, skills training and supervision are provided according to identified needs as reflected in the service plan. *See SC DHEC Regulation Number 61- 84 for specific licensing requirements. Note: The DHEC licensing requirements must be met by a CRCF provider who wishes to become a residential habilitation provider using their CRCF as the setting.*

Residential Habilitation

Standards

<u>All Models</u>

	General	Guidance
RH1.0	Residential Habilitation will be provided in accordance with all DDSN policies and procedures.	Current policies and procedures are listed in the Appendix to these standards.
RH1.1	Residential Habilitation must be provided in settings that are certified by DDSN or licensed by a DDSN Contractor.	Refer to standards for DDSN Certification and South Carolina Department of Health and Environmental Control Regulations # 61-84. Supported Living-I settings are exempt from licensing.
RH1.2	Each individual's rights of privacy, dignity and respect, and freedom from coercion and restraint are ensured.	Privacy in the resident's sleeping and living unit must be ensured. Should the resident's right to privacy require modification, any modification to this right must be supported by a specific assessed need, justified in the person's plan and reviewed by the Human Rights Committee. Positive interventions and supports must be tried before the right is modified, use of less intrusive methods must be documented, and data must be collected to review the modification. The modification must be time limited, include the informed consent of the individual, and cause no harm. Restraints used as a physician ordered health protection and restraints applied in a crisis situation are covered by DDSN Directives: • 600-05-DD: Behavior Support, Psychotropic Medications, and Prohibited Practices, and • 567-04-DD: Preventing and Responding to Disruptive Behavior and Crisis Situations. Refer to: 42 CFR §441.301(c)(4)(iii) 42 CFR §441.301(c)(4)(vi)(B) 42 CFR §441.301(c)(4)(vi) (F)(1-8)
RH 1.3	A legally enforceable agreement (lease, residency agreement, or other form of written agreement) is in place for each person in the home setting within which he/she resides. The agreement provides protections that address eviction process and appeals comparable to those provided under South Carolina's	Should the resident's right to a legally enforceable agreement require modification, any modification to this right must be supported by a specific assessed need, justified in the person's plan and reviewed by the Human Rights Committee. Positive interventions and supports must be tried before the right is modified, use of less intrusive methods must be documented, and data must be collected to review the

	Landlord Tenant Law. (S.C. Code Ann. § 27-40-10 et. seq)	modification. The modification must be time limited, include the informed consent of the individual, and cause no harm. See DDSN Directive 250-09-DD: Calculation of Room and Board for Non-ICF/IID Programs for a sample lease. Refer to: 42 CFR §441.301(c)(4)(vi)(A) 42 CFR §441.301(c)(4)(vi) (F)(1-8)
RH 1.4	Individuals who share a bedroom have a choice of roommates in that setting.	The person's preferences must be actively solicited on an on-going basis and results and documented. On-going basis means that at a minimum, on a quarterly basis. Documentation should reflect that the preferences are learned from the person and that those preferences are acted upon whenever possible within the resources of the person/provider. Should the resident's right to a choose a roommate require modification, any modification to this right must be supported by a specific assessed need, justified in the person's plan and reviewed by the Human Rights Committee. Positive interventions and supports must be tried before the right is modified, use of less intrusive methods must be documented, and data must be collected to review the modification. The modification must be time limited, include the informed consent of the individual, and cause no harm. Refer to: 42 CFR §441.301(c)(4)(ii) 42 CFR §441.301(c)(4)(iv) 42 CFR §441.301(c)(4)(vi)(B)(2) 42 CFR §441.301(c)(4)(vi) (F)(1-8)
RH 1.5	Individuals sharing homes have a choice of housemates in that setting.	
RH 1.6	Individuals have the freedom to furnish and decorate their sleeping or living units within the lease/other agreement.	Should the resident's right to furnish and decorate their sleeping unit or living units within the lease/ other agreement require modification, any modification to this right must be supported by a specific assessed need, justified in the person's plan and reviewed by the Human Rights Committee. Positive interventions and supports must be tried

		before the right is modified, use of less intrusive methods must be documented, and data must be collected to review the modification. The modification must be time limited, include the informed consent of the individual, and cause no harm. Refer to: 42 CFR §441.301(c)(4)(vi)(B)(3) 42 CFR §441.301(c)(4)(vi) (F)(1-8)
RH 1.7	The site/home must be physically accessible to the individual.	The site/home must promote free access and use of the common areas of the home such as kitchen, dining, laundry area and shared living spaces to the extent each person desires. People should not have obstructed access to areas of the common areas of the home or be confined to any one area. Confinement to an area includes "in-room time" or "quiet time in room" when imposed by the provider/staff, not chosen by the person, and not part of the person's service plan. Refer to: 42 CFR §441.301(c)(4)(vi)(E)
RH 1.8	Individuals have access to food at all times.	Any modification to this requirement must be supported by a specific assessed need, justified in the person's plan and reviewed by the Human Rights Committee. Positive interventions and supports must be tried before the modification, use of less intrusive methods documented, and data collected to review the modification. The modification must be time limited, include informed consent and cause no harm. Refer to: 42 CFR §441.301(c)(4)(vi)(C) 42 CFR §441.301(c)(4)(vi) (F)(1-8)
RH 1.9	Individuals participate in: 1) Meal Planning; 2) Grocery shopping; 3) Meal Preparation.	Refer to: 42 CFR §441.301(c)(4)(i)

RH 1.10	Individuals are able to have visitors of their choosing at any time.	This requirement does not mean that residents can be inconsiderate of the rights of others or another's need for quiet and safety in the residence. It is intended to ensure people who live in the home have the same freedoms with relationships and visitors in their homes. With any needed accommodations, residents of the house/setting should determine how they will make household decisions and how those decisions will be reviewed and modified. The residents' process for this should be documented. This process should be used if the residents choose to specify rules for visitors. If residents choose to specify rules for visitors, the "rules" should indicate the residents' decisions regarding issues such as customary visiting times, guests signing in/out of the residence, offering entry to the residence to people who are not known by all, and overnight guests. For some individuals, if positive interventions and less intrusive methods have been tried and documented but the documentation proves that the interventions were not successful, a modification may be needed. Any modification to these requirements must be supported by a specific assessed need, justified in the person-centered plan and reviewed by the Human Rights Committee. Positive interventions and supports must be tried before the modification, use of less intrusive methods documented, and data collected to review the modification. The modification must be time limited, include informed consent and cause no harm. The Residential Habilitation provider may not unilaterally prohibit or screen visitors. Refer to: 42 CFR §441.301(c)(4)(iv) 42 CFR §441.301(c)(4)(vi)(D) 42 CFR §441.301(c)(4)(vi) (F)(1-8)

	Residents Rights and Protections	Guidance
RH2.0	People are: a) Informed of their rights; b) Supported to learn about their rights. c) Supported to exercise their rights. d) Due process is upheld prior to any rights restrictions.	Rights include: Human rights, Constitutional rights and Civil rights. Training includes responsibilities as well as rights. • Training occurs a minimum of once every three (3) months. • Wide latitude is given as to how training may occur; however, documentation such as a signed training attendance sheet must exist to verify that each person received training. Should a person refuse to sign the training sheet or refuse to attend training, this should be documented on the training attendance sheet. • Each person's right to privacy, dignity and confidentiality in all aspects of life is recognized, respected and promoted. • Personal freedoms, such as the right to make a phone call in private, to decide to have a friend visit, choices as to what to have for a snack, etc. are not restricted without due process. • People are supported to manage their own funds to the extent of their capability. • Due process is upheld, including the Human Rights Committee review of restriction of personal freedoms. • People with limited knowledge and experience receive training and opportunities to explore their individual rights and the responsibilities that accompany them.
RH2.1	People are supported to make decisions and to exercise choice and control regarding their daily activities and schedules, to include: • Meal times; • Menu items; • Snack choices;	• People's activities are developed in consultation with them and according to their preferences, including but not limited to mealtime, bedtime, menu items, snack choices, restaurant choices, and community activities. • Changes that affect the person are not made without consultation with them. Any modification to this requirement must be

	• Bedtime/wake up time; • Community activities; • Doctor appointments; • Services and supports delivered, including areas of training.	supported by a specific assessed need, justified in the person-centered plan and reviewed by the Human Rights Committee. Positive interventions and supports must be tried before the modification, use of less intrusive methods documented, and data collected to review the modification. The modification must be time limited, include informed consent and cause no harm. Refer to: 42 CFR §441.301(c)(4)(iv) 42 CFR §441.301(c)(4)(vi)(C) 42 CFR §441.301(c)(4)(vi) (F)(1-8)
RH2.2	Individuals are trained on what constitutes abuse and how and to whom to report.	• Training is an ongoing process rather than a one-time event. On-going process means that information about abuse/neglect is incorporated into all aspects of the training program not a one-time, large group training experience. (e.g., discussed at meetings within residences, "rap sessions", self-advocates meetings, etc.) • Training must occur at least once every three (3) months. • Documentation must exist that verifies the person's participation in the training (e.g., signed training attendance sheet.) Should a person refuse to sign the training sheet or refuse to attend training, this should be documented on the training attendance sheet. • People who have experienced abuse receive appropriate physical, emotional and legal follow up. • People are treated with consideration and respect at all times.
RH2.3	Community Training Homes must be open to the resident at all times.	Support Providers may/should be given a break, but residents must be allowed to remain in their home. Residents will not be expected to leave during support providers breaks/vacations.
RH2.4	Each resident must be provided with a key to his/her bedroom with only appropriate staff having keys to doors.	Any modification to these requirements must be supported by a specific assessed need, justified in the person-centered plan and reviewed by the Human Rights Committee. Positive interventions and supports must be tried before the modification, use of

		less intrusive methods documented, and data collected to review the modification. The modification must be time limited, include informed consent and cause no harm. "Appropriate staff" means that the resident has decided and agreed which staff members are allowed to have keys to his/her bedroom. Refer to: 42 CFR §441.301(c)(4)(vi)(B)(1) 42 CFR §441.301(c)(4)(vi) (F)(1-8)
RH2.5	Each resident must be provided with a key to his/her home.	Any modification to these requirements must be supported by a specific assessed need, justified in the person-centered plan and reviewed by the Human Rights Committee. Positive interventions and supports must be tried before the modification, use of less intrusive methods documented, and data collected to review the modification. The modification must be time limited, include informed consent and cause no harm. Refer to: 42 CFR §441.301(c)(4)(vi)(B)(1) 42 CFR §441.301(c)(4)(vi) (F)(1-8)

	PARTICIPATION AND INTEGRATION	GUIDANCE
RH3.0	People are supported and encouraged to participate and be involved in the life of the community by: • Receiving information about opportunities for community participation. • Participating in the development of activity schedules. • Active involvement in community activities.	• People are supported to form and maintain a variety of connections, ties and involvements in the community, such as volunteering, joining clubs, shopping, dining, going to parks, ballgames, church of their choice, etc. • People are given information about opportunities for community participation, (i.e., people are made aware of community activities such as ballgames, concerts, benefits, etc.,) and are encouraged to participate in activities that interest them. • People are not forced to participate in activities; however, training to participate is provided if needed. • Documentation must exist to show evidence of participation in community activities. • Training to participate is provided if needed. Refer to: 42 CFR §441.301(c)(4)(i)
RH3.1	People are supported to maintain and enhance links with families, friends or other support networks.	• Information about the person's family, friends or other support networks is known. • The status (whether or not they are on good terms) of the relationships is known. • The person is supported to maintain contact or to re-establish contact according to his/her wishes within the ability of the Provider's resources. Refer to: 42 CFR §441.301(c)(4)(i)

	HABILITATION	GUIDANCE
RH4.0	Prior to providing residential habilitation, a preliminary plan must be developed to ensure health, safety, supervision and rights protection while the person is undergoing functional assessment for goal planning. At the time of admission, the preliminary plan for the person must be implemented.	Preliminary plan is to be implemented on the day of admission. When assessments are completed and training needs/priorities have been identified with the participation and input of the person, the residential support plan will be completed and will replace the preliminary plan. If, upon admission, the individual presents without any familial contacts, the residential provider is required to notify the DDSN State Director and provide documentation of all attempts to locate family.
RH4.1	Each individual must have a residential plan: • Developed within 30 days of admission to the setting. • Implemented within 10 working days of development. • Re-developed every 365 days.	Actively solicit the person's interests and life goals. This information may be learned in a variety of ways; however, the key is to gather this information directly from the person through direct interaction, observations or talking with someone who knows the person best. The person's preferences and goals must be the focus of the planning process. Priorization of training on assessed needs as well as personal goals should reflect the preferences of the person.
RH4.2	A comprehensive functional assessment: • Must be completed prior to the development of the initial plan. • Must be updated as needed to insure accuracy.	Assessments are individualized based on: gender, choice, ethnic background, physical abilities, adaptive functioning level and chronological age. The assessment supports skills training, care and supervision objectives identified within the person's plan. Training goals will be established based on the person's interests and priorities. Events that may trigger an assessment update may include, but not be limited to: completion of a training objective, failure to progress on a training objective, upcoming annual plan, major change in health/functioning status such as stroke, hospitalization, etc.
RH4.3	A comprehensive functional assessment must identify the abilities/strengths and needs of the person in the following areas: a) Self-care. b) Activities of daily living.	At a minimum, the functional assessment must include all areas listed. Depending on the person's priorities and preferences, additional areas may need to be assessed. Assessments must include the need to use and/or maintain prosthetic/adaptive equipment.

	c) Communication. d) Personal Health (including Self-administration of medication). e) Self-preservation. (fire evacuation, severe weather, general safety, etc.) f) Self-supervision at all times. g) Rights. h) Personal finances/money. i) Community involvement. j) Social Network/Family Relationships. k) Personal property maintenance/management.	Self-Care: a) Bowel/bladder care. b) Bathing/grooming. (including ability to regulate water temperature) c) Dressing. d) Eating. e) Ambulation/Mobility. Personal Health: a) Need for professional medical care. (how often, what care) b) Ability to treat self or identify the need to seek assistance. c) Ability to administer own meds/treatments. (routine, time limited, etc.) d) Ability to administer over the counter medications for acute illness. e) Ability to seek assistance when needed. Self-Preservation: a) Respond to emergency. b) Practice routine safety measures. c) Avoid hazards. d) Manage (use/avoid) potentially harmful household substances. e) Ability to regulate water temperature. Self-Supervision: a) Need for supervision during bathing, dining, sleeping, other times during the day. b) Ability to manage own behavior. Rights: a) Human Rights: established by the United Nations that all people are entitled to by virtue of the fact that they are human. (i.e., Life, liberty and security of person, right not to be subjected to torture, etc.)

		b) Civil Rights: guaranteed by law. (i.e., Americans with Disabilities Act) c) Constitutional Rights: guaranteed by the Constitution of the United States. (i.e., free speech, right to due process, etc.) <u>Personal finances/money</u>: People are expected to manage their own money to the extent of their ability. <u>Community Involvement</u>: a) Extent of involvement. b) Awareness of community activities. c) Frequency. d) Type. <u>Social network/family relationships</u>: a) Family and friends. b) Status of relationships. c) Desired contact. d) Support to re-establish/maintain contact. e) If without social network or family relationship: 1. Provider will notify DDSN that this situation exists. 2. All efforts to locate relatives are documented annually. Supported Living Assessment for those residing in **<u>SLP-I only</u>**. Assessments are to be done using the Supported Living assessment tool available on CDSS. Assessments must be done: a) On new sites. b) On sites when address has changed. c) Annually at the time of the person's plan.

		All assessments on new sites and sites where address has changed must be sent to the DDSN District Office for approval and forwarded to Quality Assurance in the DDSN Central Office. Annual assessments on which any item is marked "no" must have a plan to address the item that has been approved by the appropriate DDSN District Office. Assessments on which all items are marked "yes" require no further approval beyond the Provider level.
RH4.4	The plan must include the person's goals/objectives related to Residential Habilitation including: a) The type and frequency of care to be provided. b) The functional skills training to be provided. c) The type and frequency of supervision to be provided. d) Any other supports to be provided. e) Description of how each support will be documented.	Care: Assistance with or completion of tasks that cannot be completed by the person and about which the person is not being taught (including, but not limited to, regulation of water temperature, fire evacuation needs, etc. Functional: Activities/skills/abilities that are frequently required in natural domestic or community environments. Skills training: Should center on teaching the most useful skills/abilities for the person according to their priorities. Every consideration should be given to adaptations that could make the task easier/more quickly learned. Supervision: Oversight by another provided according to DDSN policy and must be as specific as needed to allow freedom while assuring safety and welfare (including supervision when around water that exceeds 110 degrees F). May include electronic supervision when appropriate. As a general rule each individual should have a minimum of three skill acquisition objectives.
RH4.5	Within ten (10) working days of the end of the quarter, a report of the status of the goals in the plan and the supports provided to achieve those goals must be completed with input from the person.	Quarterly summary is routinely shared with the Case Manager.
RH4.6	Residents who attend school are supported as needed to enable them to benefit fully from their school experience.	Support includes, but is not limited to, helping with homework, assistance to participate in school activities and functions, working in conjunction with school personnel on issues, responding to correspondence from the school. When recipient is a minor, an understanding regarding participation with the guardian must be reached.

RH4.7	The effectiveness of the residential plan is monitored and the plan is amended when: a) No progress is noted on a goal. b) A new strategy, training or support is identified; or c) The person is not satisfied with the support.	Data should be analyzed monthly to see that training has been completed as scheduled and data is collected as prescribed and accurate. Incorrect data calculations/analysis will be cited if the errors affect the outcome of the plan monitoring (e.g., indicates progress was made when progress did not occur and goal should have been revised.). Corrective action is taken and recorded when: The plan is not implemented as written by staff; when the support yields 100% accuracy the first month; there is no correlation between recorded data and observed individual performance; the health, safety and welfare of people is not maintained; when the person is not satisfied with the support, etc. As a general rule, if no progress has been noted for three (3) consecutive months with no reasonable justification for the lack of progress, the plan must be amended.

	Intensive Behavioral Intervention	Guidance
RH5.0	When the person exhibits behavior that: • Poses a risk to him/herself, others, or the environment; • Interferes with his/her ability to function in his/her typical environments, • Interferes with his/her ability to acquire, gain or maintain skills, abilities and/or independence, and/or • Interferes with his/her ability to participate in the life of the community, Then the problem behavior must be addressed.	Problem Behavior is defined as behavior that, when exhibited, • Poses a risk to him/herself, others, or the environment; • Interferes with his/her ability to function in his/her typical environments, • Interferes with his/her ability to acquire, gain or maintain skills, abilities and/or independence, and/or • Interferes with his/her ability to participate in the life of the community, DDSN Directive 600-05-DD: Behavior Support, Psychotropic Medications and Prohibited Practices, must be followed.
RH5.1	Prior to the development to of a Behavior Support Plan, indirect assessment must be conducted by the Intensive Behavioral Intervention provider. Indirect assessment includes: a) Record review, including but not limited to, a review of the Residential Plan, supervision plan, and if available any existing Behavior Support Plans. b) Interview using the Functional Assessment Interview Form (O'Neill, et al., 2014) or another empirically validated functional assessment instrument – such as the QABF (Questions About Behavioral Function, Matson & Vollmer, 1995) – with two or more people who spend the most time with the person (can include the person). Must include (or be supplemented by additional assessment documentation which includes) the following: 1. Description of problem behavior. 2. Listing of ecological and setting events that predict the occurrence	Written information indicating that each component of the assessment was conducted must be available. Summary Statements are defined as specific hypothesis statements for each distinct context or maintaining function of the behavior. Typically states the suspected or determined setting event, antecedent, behavior, consequence contingency. "Functional Assessment Interview" forms can be found on the DDSN Applications Portal >Business Tools >Forms > All Residential.

	and/or non-occurrence of the behavior. 3. Listing of possible antecedents that predict the occurrence and/or non-occurrence of the behavior. 4. Listing of possible consequences (access, escape/avoid, automatic) that maintain the problem behavior. 5. Record of information on the efficiency of the problem behavior. 6. List of functional alternatives the person currently demonstrates. 7. Description of the person's communication skills. 8. Description of what to do and what to avoid in teaching. 9. Listing of what the person likes (potential reinforcers). 10. Listing of the history of the problem behavior(s), previous interventions, and effectiveness of those efforts. c) Development of summary statements based on the Functional Assessment Interview (contains information on setting events, antecedents, problem behavior, and consequences).	
RH5.2	Direct Assessment must be conducted by the Intensive Behavioral Intervention provider to verify the indirect assessment information. This includes: Observational data collection forms and/or observational summaries that represent <u>two (2) or more sessions</u> using A-B-C recording in direct observation for a minimum of: 1) <u>Three (3) or more total hours or</u>	A-B-C Recording or A-B-C Data is defined as a form of direct, continuous observation in which the observer records a descriptive, temporally-sequenced account of all behavior(s) of interest and the antecedent conditions and consequences for those behaviors as those events occur in the client's natural environment. A summary must be included in the functional assessment (document) that includes the relative frequency of specific antecedents and consequences for individual problem behaviors. This can be either a table or narrative format.

<table>
<tr><td></td><td>2) <u>20 occurrences of the target behavior(s)</u>.

If no problem behavior is observed, observational information must be summarized to describe contexts that support the non-occurrence of target behavior.

If observational data do not verify the indirect assessment information, then the summary statements must be revised to correspond to the direct assessment data.</td><td>Frequency is defined as a ratio of count per observation time; often expressed as count per standard unit of time (e.g., per minute, per hour, per day) and calculated by dividing the number of responses recorded by the number of standard units of time in which observations were conducted; used interchangeably with rate.

The functional assessment is a document that can be separate from the BSP (conclusions referenced in the BSP) or included in the BSP. In either case, the entire functional assessment document must be available for review.

If during observations no target behaviors are observed, the IBI provider must either include summarized A-B-C data from staff observations or conduct additional observations that do include occurrences of the target behavior(s).</td></tr>
<tr><td>RH5.3</td><td>Behavior Support Plans must contain:

a) Description of the person:

1) Name, age, gender, residential setting,

2) Diagnoses (medical and psychiatric),

3) Intellectual and adaptive functioning,

4) Medications (medical and psychiatric),

5) Health concerns,

6) Mobility status,

7) Communication skills,

8) Daily living skills,

9) Typical activities and environments,

10) Supervision levels,

11) Preferred activities, items, and people, and

12) Non-preferred activities, items, and people.</td><td>a) The BSP should include brief, specific descriptions of each item <u>and how they relate, or don’t relate, to issues of behavior support</u>.

b) Specified in BSP

c) Problem Behavior is defined as behavior that, when exhibited:

• Poses a risk to him/herself, others, or the environment;

• Interferes with his/her ability to function in his/her typical environments;

• Interferes with his/her ability to acquire, gain or maintain skills, abilities and/or independence; and/or

• Interferes with his/her ability to participate in the life of the community.

Replacement behavior is defined as a socially-acceptable, functionally-equivalent behavior that could produce the same consequence as the problem behavior.

d) Summary statements per problem behavior based on A-B-C data must be included in the BSP. These statements provide the hypotheses</td></tr>
</table>

	b) Locations where BSP will be implemented and identification of program implementers. c) Description of Problem Behavior and Replacement Behavior are defined in terms that are observable, measurable, and on which two independent observers can agree. d) Summary of direct assessment results. e) Objectives for each problem behavior, including: 1) Person's name, 2) Operational, measurable and observable way to describe behavior, 3) Conditions under which the behavior occurs or should occur, and 4) Criteria for completion (performance and time) f) Competing Behavior Model for each class of problem behavior that includes function of problem behavior and replacement behavior based on direct assessment g) Objectives for each replacement behavior, including: 1) Person's name, 2) Measurable and observable way to describe behavior, 3) Conditions under which the behavior occurs or should occur, and 4) Criteria for completion (performance and time).	about the context and/or maintaining function of the behavior. They include the likely antecedent, behavior, and consequence information. Reliability coefficients (while not required) would be appropriate here. e) "Operational, measurable and observable ways to describe behavior" examples include: • Verbal Aggression > Cursing, threatening to harm others, calling others derogatory names, or all three behaviors. • Self-Injury > Biting own wrist and/or own hand. f) "Competing Behavior Model" form, adapted from O'Neill, et al, 2014) can be found on the DDSN Applications Portal >Business Tools> Forms> All Residential. g) Example: Objectives for Replacement Behavior: 1. Bobby will complete all tasks in his photographic activity schedule with 90% of tasks complete for 3 consecutive months by 6/1/17. 2. When presented with non-preferred tasks, Sue will say "no thank you" to escape or postpone the task, 100% of the trials by 6/1/17. 3. When the environment becomes too noisy or overstimulating, Mary will request a break by stating "I need a break please" for 75% of opportunities for 1 month by July 30, 2017. h) Support Procedures 1) Antecedents identified in the assessment must be addressed in the intervention (e.g., changing a difficult task). 2) Teaching strategies must be consistent with behavioral principles and teach desired/replacement behaviors (e.g., teaching a response to ask for help). 3) Reinforcement procedures to increase/maintain appropriate behavior must be included (can be in teaching procedures). Withholding reinforcement for problem behavior may also be specified.

	h) Support Procedures 1) Setting Event/Antecedent Strategies 2) Teaching Strategies 3) Consequence Strategies 4) Crisis Management Strategies 5) Data Recording Method 6) Data Collection Forms	4) Crisis management strategies must include strategies to ensure the safety of the person and others. This should include techniques from a competency-based curriculum to prevent and respond to dangerous behavior (e.g., MANDT, PCM, etc.) if such behaviors are exhibited by the person. 5) The data recording method must describe where, when, how and how often behavioral data are to be collected. Must also include: occurrence of problem behavior, occurrence of replacement behavior, and the data recording method (i.e., frequency, duration, response latency, or percent of trials). Frequency is defined as a ratio of count per observation time; often expressed as count per standard unit of time (e.g., per minute, per hour, per day) and calculated by dividing the number of responses recorded by the number of standard units of time in which observations were conducted; used interchangeably with rate. Duration is defined as a measure of the total extent of time during which a behavior occurs. Response latency is defined as a measure of the elapsed time from the onset of a stimulus (e.g., task direction, cue) to the initiation of a response. Percent of trials is defined as the percentage of correct responses out of the total number of opportunities, or the total number of observation intervals scored for occurrence of the problem behavior. 6) The data collection forms must include: person's name, date(s) of data collection, location of data collection, operational definition for the problem behavior and the replacement behavior, instructions for data collection, an organized format to collect numerical data, and signature or initials of Direct Support Professionals (DSP's) who collect data. Direct Support Professional (DSP) are defined as paid day/residential program staff members, house managers, teachers, therapists, etc.

RH5.4	Behavior Support Plan Implementation a) DSP(s) responsible for implementing a BSP must be fully trained to: 1) Collect behavioral data, and 2) Implement the BSP procedures. b) Procedures for training DSP(s) on implementation must include: 1) Written and verbal instruction; 2) Modeling; 3) Rehearsal; and 4) Trainer feedback. c) Documentation of DSP(s) training must accompany the plan and must include: 1) Person's name; 2) Date of initial training; 3) Date of additional DSP(s) training; 4) Names and signatures of DSP(s) trained; and 5) Name of trainer and/or authorized secondary trainer. d) Fidelity procedures completed by the Intensive Behavioral Intervention provider must occur quarterly and must document <u>direct observation of DSP(s) implementing procedures according to the plan</u>. Documentation must include: 1) Person's name; 2) Name(s) of DSP(s) being observed; 3) Date, location and time (including duration) of observation;	The "Behavior Support Plan Training Documentation" form can be found on the DDSN Applications Portal >Business Tools >Forms > All Residential. The use of this form to document the training provided is optional. a) Procedures for training DSP(s) and/or caregivers must be documented in either the BSP, training materials, or training documentation. b) Documentation of DSP/caregiver training must be present to indicate that training occurred prior to the effective date/implementation date of any addendum/amendment to the BSP. Documentation must specify: 1) Training on observation and behavioral data collection system and on treatment procedures, and 2) Retraining on collection of behavioral data and/or BSP implementation procedures. c) If opportunities to observe: 1) Antecedent, teaching, or consequence strategies for acceptable behavior; 2) Response strategies to problem behavior; or 3) Both are infrequent or not observed during a fidelity check, it would be sufficient to observe the DSP(s) practicing the BSP procedures by role-play with the IBI provider acting the part of the person. If the BSP addresses more than one setting (e.g., Day Program, Home, etc.), then the fidelity checks should, on a rotating basis, be conducted in each setting addressed by the plan. "Fidelity Procedures Documentation" forms can be found on the DDSN Applications Portal >Business Tools >Forms > All Residential.

<table>
<tr><td></td><td>4) Description of procedures observed;

5) Directions and/or description of DSP performance;

6) Signature of observed caregiver(s); and

7) Signature of the observer.</td><td></td></tr>
<tr><td>RH5.5</td><td>Progress monitoring by the Intensive Behavioral Intervention provider must occur at least monthly and rely on progress summary notes that include:

a) Graphs that are legible and contain:

1) Title related to behavior measured,

2) X- and Y-axis that are scaled and labeled

3) Labeled gridlines

4) Consecutive and connected data points,

5) Legend for data points (when more than one type is used), and

6) Phase lines and labels for changes (i.e., programmatic, environmental, medical, and/or medication changes)

b) Visual analysis that includes description of the level, trend, and variability of each behavior along with discussion related to programmatic, environmental, medical, and/or medication changes

c) Future (planned) implementation must be described and include any barriers that need to be addressed (e.g., inaccurate implementation, incomplete data collection, etc.), and any changes that need to be made to the procedures based on lack of progress or deteriorating performance, and</td><td>Monitoring is reflected in the monthly progress note.

a) Graph must be available and contain noted elements.

Phase lines are defined as vertical lines drawn upward from the horizontal axis on a graph to show points in time at which changes in the independent variable occurred (also referred to as condition change lines).

Phase labels are defined as labels, in the form of single words or brief descriptive phrases, are printed along the top of the graph and parallel to the horizontal axis (also referred to as condition labels).

b) The progress note should describe these items related to the desired outcome in the objective. Level is defined as the value on the vertical axis around which a series of behavioral measures converge.

Trend is defined as the overall direction taken by a data path. It is described in terms of direction (increasing, decreasing, or zero trend), degree (gradual or steep), and the extent of variability of data points around the trend. Trend is used in predicting future measures of the behavior under unchanging conditions.

Variability is defined as the frequency and extent to which multiple measures of behavior yield different outcomes.

c) The progress note should describe these items related to the desired outcome in the objective.

d.) Desired behavior is defined as socially acceptable behavior targeted for increase.</td></tr>
</table>

	d) If fidelity procedures reveal that the BSP is being properly implemented and data properly collected, yet no progress is observed for the problem behavior, replacement behavior, or desired behavior for three (3) consecutive months, then a meeting with the DSP(s), Intensive Behavioral Intervention provider, and others on the support team as appropriate must be conducted to revisit the Functional Assessment and its summary and to determine the benefits of revisiting, modifying or augmenting BSP procedures or of enhancing DSP training.	This would be documented by a dated, titled meeting sign in sheet identifying the person the reason(s) for lack of progress, and the revisions to BSP procedures that are to be implemented and DSP(s) to be trained for the revision, or justification for no revision. Signature sheets must be available. Note: If the fidelity procedures reveal that the BSP is not being properly implemented or data are not being properly collected, then re-training of the DSP(s) is sufficient, and no team meetings or plan modifications are required.

	Health	Guidance
RH6.0	People receive coordinated and continuous health care services based on each person's specific health needs, condition, and desires.	Continuous health care includes acute and emergency care. Continuous means through-out entire life span. Coordinated means that people have a medical home/primary physician, (unless they choose otherwise) who is aware of their history, medical condition, other health care specialist involved, etc. People actively participate in their health care decisions according to their skills and abilities. People with specific health concerns, such as seizures, people who are prone to aspirate, etc., receive individualized care and follow-up. People are supported to develop/maintain a healthy lifestyle and to engage in wellness activities which may include, but not be limited to: nutrition/weight management and physical fitness activities through involvement in programs such as Steps To Your Health, YMCA membership, etc. Health conditions such as dysphagia and GERD are ruled out before behaviors such as rumination, intentional vomiting, etc., are addressed behaviorally. People receive a health examination by a licensed physician who determines the need for and frequency of medical care and there is documentation that the physician's recommendations are being followed. The health care received is comparable to any person of the same age, group and sex. (i.e., mammogram for females 40 and above, annual pap smears, prostate checks for males over 50, etc.) People receive a dental examination by a licensed dentist who determines the need for and frequency of dental care and there is documentation that the dentist's recommendations are being carried out. The provider notifies the behavior support provider in advance of the date, time and location of the periodic drug review (PDR). Staff who support the person have the tools/equipment needed and the skills/knowledge to do so appropriately.

RH6.1	The Residential Habilitation provider must have procedures that specify the actions to be taken to assure that within 24 hours following a visit to a physician, Certified Nurse Practitioner, or Physician's Assistant all ordered treatments will be provided.	The procedures must specify the exact steps to be taken and by whom, including but not limited to, specifying to whom orders are to be given upon return from the physician's visit; who is responsible for obtaining medications, supplies or equipment from the pharmacy or other supplier; who is responsible for scheduling follow-up visits, visits to specialists, or visits for further testing; who is responsible for training direct support staff and providing those staff with appropriate written instructions for complying with the orders, etc. A system is in place to assure that orders are followed and the specific staff have been assigned and are responsible for specific tasks.
RH6.2	The Residential Habilitation provider must have available at all times a health care professional that can assess a resident's health condition, determine appropriate intervention to be provided, and give specific instruction to staff who will provide the intervention.	The contact information for the health care professional must be posted or easily accessible in all residences. Staff must know how to contact the professional and be instructed and encouraged to do so as often as needed. Providers are encouraged to utilize resources effectively and efficiently while assuring that staff has access to a health care professional. This professional may be a nurse hired or contracted by the agency, or a nurse available through a physician's office, or a local "ask-a-nurse" line through a hospital or other health care organization, etc. The source used to provide access to staff is not restricted by this requirement.
RH6.3	Between 24-36 hours after being seen by a Physician, Physician's Assistant or Certified Nurse Practitioner for acute care, the person must be evaluated to determine the status of his/her condition.	The evaluation may be done by a staff member who is not a nurse and is not a health care professional. However, the designated staff member may not be a staff person who provides direct support to those who receive residential habilitation services. If the acute care visit is self-initiated or initiated by family members without the knowledge of the residential provider, this requirement would not apply. In these situations, within 24 hours of returning to the setting or learning about the visit, the provider must assure that medications, supplies or equipment needed to comply with the orders from the visit are available in the setting. "Acute" is defined as treatment sought for a brief and severe condition, as opposed to treatment for chronic long term conditions, routine check-ups, or follow-up visits for previously diagnosed illnesses. Acute visits are not planned in advance, but are in response to a sudden change in condition or an accident, such as a sinus infection, urinary tract infection, the flu, a broken arm, a laceration, etc.

		To evaluate, the staff member must: 1. See the person in his/her home. 2. Determine if the person’s condition has improved, worsened or remained unchanged. 3. Review the orders/instructions given as a result of the Certified Nurse Practitioner, Physician’s Assistant or Physician’s visit or discharge from the hospital in order to determine if needed medications, supplies and equipment are available and in sufficient quantity to comply with the orders. 4. Determine if staff can competently perform the duties required to comply with the orders. If staff are not observed performing the duties, determine if staff has been given clear and accurate instructions or materials that are easily understood and aid in their ability to competently perform the duties. 5. Determine if staff can identify the worsening or lack of improvement of the person’s condition or if staff have been given instructions regarding how to identify the worsening or lack of improvement of the person’s condition. 6. Determine if staff know or have been given specific instructions regarding what to do: • If the condition worsens or doesn’t improve as expected; • If they have questions about how to comply with the orders; and/or • If they need supplies, equipment, medication in order to comply with the orders. 7. Report immediately (before leaving the residence) to the Executive Director or designee situations in which: • Medications, supplies and/or equipment are not available; • Staff on duty do not appear to be competent to fulfill the orders nor have they been given

		clear and accurate instructions or materials to aid in the competent completion of the duties; and/or • The person's condition has worsened or has not adequately improved and no action has been taken to address. Following the verbal report, staff must complete sign and date a report of the evaluation that provides a detailed description of the adverse findings(s) and actions(s) taken. 8. Provide the original report to the Executive Director/designee within 48 hours of the completion or the next business day, whichever is later. **Note:** Any situation reported to the Executive Director/designee as outlined in #7 (above) will be considered an unusual and unfavorable occurrence that has harmful or otherwise negative effects to the person and therefore, must be reported to DDSN following the steps outlined in DDSN Directive 100-09-DD: Reporting of Critical Incidents.

	STAFF	GUIDANCE
RH7.0	Support providers must meet requirements for criminal background checks.	Reference DDSN Directive 406-04-DD: Criminal Records Checks and Reference Checks of Direct Caregivers, for additional requirements and guidance.
RH7.1	Staff must have a driver's license check prior to transporting people who receive services.	Provider should have a system in place for period re-checks on a random basis.
RH7.2	The provider must designate a staff member who is responsible for developing and monitoring the person's residential plan and who meets the following qualifications: a) A bachelor's degree in human services from an accredited college or university; b) Is at least 21 years of age; c) Has at least one (1) year of experience (e.g., paid or voluntary) working directly with persons with an intellectual disability or a related disability.	"Human Services" = human behavior (e.g., psychology, sociology, speech communication, gerontology etc.), human skill development (e.g., education, counseling, human development), humans and their cultural behavior (e.g., anthropology), or any other study of services related to basic human care needs (e.g., rehabilitation counseling), or the human condition (e.g., literature, the arts). The provider can exercise wide latitude of judgment to determine what constitutes "human services." The key concern is the demonstrated competency to do the job.
RH7.3	Support providers must be at least eighteen 18 years of age and have a high school diploma or its equivalent.	Competency in the following areas may be considered the equivalent to a high school diploma. Employees must be able to: a. Read and comprehend written instructions which may include health care information; b. Write information sufficient to communicate facts clearly; c. Communicate verbal or written information effectively to others. Documentation demonstrating competency in items a. through c., must be maintained in the employee's file.
RH7.4	Support providers must pass an initial physical exam prior to working in the home.	Pass means no documentation in the physical exam report of conditions present that would jeopardize health and safety of people receiving services or staff's ability to perform required duties.

RH7.5	Support providers must pass initial tuberculosis screening prior to working in the home and annually thereafter.	Pass = no evidence of communicable disease (see DDSN Directive 603-06-DD: Guidelines for Screening for Tuberculosis, for possible exceptions to annual screening).
RH7.6	Community Training Homes-I adult household members must meet the following requirements: a) Appropriate background checks. b) Initial health exam conducted by a licensed physician, physician's assistant or licensed nurse practitioner. c) Tuberculosis screening initially and annually thereafter.	Household member means an individual 18 years of age or older who resides in the Community Training Home-I Residence. See DDSN Directive 406-04-DD: Criminal Records Checks and Reference Checks of Direct Caregivers, for additional requirements and guidance. See DDSN Directive 603-06-DD: Guidelines for Screening for Tuberculosis, for additional requirements and guidance.
RH7.7	When, as part of the Residential Habilitation provided to the person, Intensive Behavioral Intervention is used to address problem behavior, Intensive Behavior Intervention will be provided by someone who: • Is a Board Certified Behavior Analyst-Doctoral™ (BCBA-D™); • Is a Board Certified Behavior Analyst® (BCBA®); • Possesses at least a Master's degree in behavior analysis, psychology, special education or a closely related field and has a minimum of two (2) years of experience in the use of the principles of applied behavior analysis in the habilitation of people with intellectual disabilities/related disabilities including experience in the development of Behavior Support Plans. • Medicaid enrolled providers of Behavior Support Services who are in pursuit of BCBA/BCaBA certification who annually submit documentation of continuous, active pursuit of certification to DDSN may provide IBI until June 30, 2018.	While not required, prior to engaging an Intensive Behavioral Intervention (IBI) provider, information about the IBI provider's current certification, educational and/or vocational history and sample of his/her work may be submitted to DDSN for review. The review will be conducted using the requirements for IBI within these Residential Habilitation Standards. This review will be completed as a courtesy and results provided; DDSN will not approve or recommend the engagement of the IBI provider. When employing a Board Certified Assistant Behavior Analyst (BCaBA), it is important to note that according to the Behavior Analyst Certification Board® (BACB), every BCaBA must practice under the supervision of a qualified supervisor." Supervisor qualifications can be found in the BACB "Standards for Supervision of BcaBA" and state: "BCaBA supervisors must hold a qualifying credential, have completed specific training, and have completed steps with the BACB to acknowledge the supervisory relationship prior to providing any supervision. The specific requirements are described below: • Credential: The supervisor must hold a current Board Certified Behavior Analyst® (BCBA®) or Board Certified Behavior Analyst–Doctoral™ (BCBA-D™) credential, or be a licensed or registered psychologist certified by the American Board of Professional Psychology in Behavioral and Cognitive Psychology and who was tested in Applied Behavior Analysis. • Training: The supervisor must complete an 8-hour training based on the BACB's Supervisor Training Curriculum

		Outline before providing any supervision. Supervisors who are certified at the BCBA or BCBA-D levels must also complete ongoing supervision continuing education as part of their recertification requirements. • BACB Reporting: The supervisor must acknowledge the supervisory relationship through entry of supervisee information in the supervisor's BACB Gateway account. Supervisors will be publicly identified in the BCaBA's record on the BACB Certificant Registry. The supervisor is responsible and can be held accountable under the BACB Professional and Ethical Compliance Code for Behavior Analysts (Compliance Code) for the services provided by the BCaBA. Note: The supervisor may not be related to, subordinate to, or employed by the BCaBA. Employment does not include compensation received by the supervisor from the BCaBA for supervision services. While not required, it is preferable that the supervisor be someone who works most closely with the BCaBA in implementing behavior analytic services." The Residential Habilitation provider must maintain evidence of the completion of the required continuing education for those possessing a Master's degree and experience.

	DOCUMENTATION	GUIDANCE
RH8.0	Documentation/data must be: A. True and accurate. B. Complete. C. Legible. D. Logically sequenced.	• DDSN Directive 167-06-DD: Confidentiality of Personal Information. • DDSN Directive 368-01-DD: Individual Service Delivery Records Management. • The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. • Late entries (i.e., notes entered into the record more than 24 hours after the activity which is described) must be identified as such.
RH8.1	Documentation/data must be entered into Therap and be sufficient to support the implementation of the plan and the provision of Residential Habilitation for each unit of service reported.	For Residential Habilitation, one (1) unit of service equals one (1) day when services are provided in models other than Supported Living I. In the Supported Living I model, one (1) unit equals one (1) hour. Documentation/data must be available to support that Residential Habilitation was provided each time the individual is reported to have received the service. Documentation of the provision of Residential Habilitation must be available to support the provision of the service. Documentation of service provision includes: • Completed residential assessments; • Completed residential plans; • Completed Residential Log which indicates "present." • Data showing the implementation of skills training included in the participant's Residential Plan; • Data showing the implementation of the participant's Behavior Support Plan; • Data showing the implementation of supervision in accordance with the Supervision Plan; • Data showing the provision for care including: o Medication administration records when the person is incapable of administering his/her own medications and/or medical treatments;

		o Documentation of assistance with activities of daily living when the person is incapable of completing without assistance; o Documentation of assistance with instrumental activities of daily living when the participant is incapable of completing those activities without assistance; o Documentation of transportation to and assistance with the receipt of health care services based on each participant's specific health needs, condition, and desires.

	REPORTING	GUIDANCE
RH9.0	Reporting requirements must be performed correctly.	DDSN Directive 100-09-DD: Reporting of Critical Incidents. DDSN Directive 505-02-DD: Death or Impending Death of Persons Receiving Services. DDSN Directive 534-02-DD: Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contracted Provider Agency

Appendix
Additional Guidance

Residential Habilitation must be provided in accordance with all applicable DDSN contracts, policies, procedures, and standards and applicable federal, state and local laws, including but not limited to:

Resident's Rights and Protections

100-17-DD: Family Involvement
167-06-DD: Confidentiality of Personal Information
535-02-DD: Human Rights Committee
535-07-DD: Obtaining Consent for Minors and Adults
535-08-DD: Concerns of People Receiving Services: Reporting and Resolution
535-10-DD: National Voter Registration Act (Motor Voter)
535-11-DD: Appeal and Reconsideration Policy and Procedures

The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191
http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

S.C. Codes of Law § 44-26-10 to § 44-26-220 Rights of Clients with Intellectual Disability
http://www.scstatehouse.gov/code/t44c026.php.

Compliance with Title VI of the Civil Rights Act of 1964, American's with Disabilities Act of 1990, Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973 and Establishment of a Complaint Process (cross reference DDSN Directive 700-02-DD).

Personal Funds and Property

200-12-DD: Management of Funds for Individuals Participating in Community Residential Programs
604-01-DD: Individual Clothing and Personal Property

Health

100-12-DD: Aids Policy
100-29-DD: Medication Error/Event Reporting
533-02-DD: Sexual Assault Prevention, and Incident Procedure Follow-Up
603-01-DD: Tardive Dyskinesia Monitoring
603-06-DD: Guidelines for Screening for Tuberculosis
603-13-DD: Medication Technician Certification
604-04-DD: Standard First Aid with Cardiopulmonary Resuscitation (CPR) – Adult, Child, Infant

Health Care Guidelines

Behavior

101-02-DD: Preventing and Responding to Suicidal Behavior
600-05-DD: Behavior Support, Psychotropic Medications and Prohibited Practices

Reporting

100-09-DD: Critical Incident Reporting
368-01-DD: Individual Service Delivery Records Management
505-02-DD: Death or Impending Death of Persons Receiving Services from DDSN
534-02-DD: Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contracted Provider Agency

Finance Manual, Sections 10.1 and 10.7

Certification and Licensure

104-01-DD: Certification and Licensure of DDSN Residential and Day Facilities
167-01-DD: Appeal Procedure for Facilities Licensed or Certified by DDSN

Staff

406-04-DD: Criminal Records Checks and Reference Checks of Direct Caregivers
567-01-DD: Employee Orientation, Pre-Service and Annual Training Requirements
567-04-DD: Preventing and Responding to Disruptive Behavior and Crisis Situations

General

100-25-DD: Disaster Preparedness Plan for DDSN and Other DDSN Providers of Services to Persons with Disabilities and Special Needs
100-26-DD: Risk Management Program
502-01-DD: Admissions/Discharge of Individuals to/from DDSN Funded Community Residential Setting