Continuing Care Retirement Community

Standards Manual

2020
July 1, 2020–June 30, 2021
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CARF International is a private, nonprofit organization that is financed by fees from accreditation surveys, workshops, and conferences; sales of publications; and grants from public entities. The CARF International group of companies includes:

- CARF
- CARF Canada
- CARF Europe

Since its inception in 1966, CARF has benefited from organizations joining together in support of the goals of accreditation. These organizations, representing a broad range of expertise, sponsor CARF by providing input on standards and other related matters through membership in CARF’s International Advisory Council (IAC). A list of current IAC members is available on the CARF website, www.carf.org/members.

**Mission**

The mission of CARF is to promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of the persons served.

**Vision**

Through responsiveness to a dynamic and diverse environment, CARF serves as a catalyst for improving the quality of life of the persons served.

**Moral Ownership**

The CARF Board of Directors has identified that the persons served, as defined below, shall be the moral owners of CARF. *Persons served* are the primary consumers of services. When these persons are unable to exercise self-representation at any point in the decision-making process, *persons served* is interpreted to also refer to those persons willing, able, and legally authorized to make decisions on behalf of the primary consumer.

**Values**

CARF believes in the following core values:

- All people have the right to be treated with dignity and respect.
- All people should have access to needed services that achieve optimal outcomes.
- All people should be empowered to exercise informed choice.

CARF’s accreditation, research, continuous improvement services, and educational activities are conducted in accordance with these core values and with the utmost integrity. In addition, CARF is committed to:

- The continuous improvement of both organizational management and service delivery.
- Diversity and cultural competence in all CARF activities and associations.
- Enhancing the involvement of persons served in all of CARF’s activities.
- Persons served being active participants in the development and application of standards of accreditation.
- Enhancing the meaning, value, and relevance of accreditation to persons served.
Purposes

In support of our mission, vision, and values, CARF’s purposes are:

- To develop and maintain current, field-driven standards that improve the value and responsiveness of the programs and services delivered to people in need of life enhancement services.
- To recognize organizations that achieve accreditation through a consultative peer-review process and demonstrate their commitment to the continuous improvement of their programs and services with a focus on the needs and outcomes of the persons served.
- To conduct accreditation research emphasizing outcomes measurement and management and to provide information on common program strengths as well as areas needing improvement.
- To provide consultation, education, training, and publications that support organizations in achieving and maintaining accreditation of their programs and services.
- To provide information and education to persons served and other stakeholders on the value of accreditation.
- To seek input and to be responsive to persons served and other stakeholders.
- To provide continuous improvement services to improve the outcomes for organizations and the persons served and their community of influence.

Development of the Standards

The CARF standards have evolved and been refined over 50 years with the active support and involvement of providers, consumers, and purchasers of services. The standards are maintained as international consensus standards. The standards define the expected input, processes, and outcomes of programs for persons served. CARF recognizes and accepts its responsibility to assess and review the continuing applicability and relevance of its standards. CARF convenes its International Advisory Council; advisory committees; and regional, national, and international focus groups to systematically review and revise CARF’s standards and develop standards for new accreditation opportunities. Composed of individuals with acknowledged expertise and experience, these committees and groups, including persons served, make recommendations to CARF concerning the adequacy and appropriateness of the standards.

This work is viewed as a starting point in the process of standards development and revision. Recommendations from this input are used to develop proposed new and revised standards, which are then made available for review by the public, persons served, organizations, surveyors, national professional groups, advocacy groups, third-party purchasers, and other stakeholders. This input from the field is carefully scrutinized by CARF and results in changes to the standards.
Applying the Standards

The organization is expected to demonstrate conformance to the **applicable standards** during the site survey so that the survey team can determine the organization’s survey findings and, ultimately, allow CARF to determine the accreditation decision. On subsequent surveys, the organization is expected to demonstrate continuous conformance from any previous period of CARF accreditation.

Some sections of the standards, such as the ASPIRE to Excellence® section which relates to the overall business practices of the organization, are applicable regardless of the programs or services for which the organization is seeking accreditation. The standards in other sections are applicable in accordance with instructions in those sections.

Some standards have **intent statements** that help to explain, clarify, and provide additional information about the standard. When there is an intent statement, it immediately follows the standard to which it relates.

Some intent statements are followed by **examples** that illustrate potential ways an organization may demonstrate conformance to the standard.

Some standards may suggest **resources** that an organization may find helpful in implementing or conforming to the standards. Resources may include references to websites, organizations, or publications that provide information or assistance relevant to topics or areas included in the standard.

**Note:** Before initiating the self-evaluation process or applying for a survey, an organization should contact CARF to discuss the programs and services it intends to include in the accreditation process. This step helps determine which standards will be applicable. If an organization provides a program or service that is not listed in this manual, the organization should also contact CARF for more information.
CARF Publications

CARF offers publications and products through the online store at www.carf.org/catalog. Publications are available in alternative formats to accommodate persons with disabilities. Please contact CARF’s Publications department at (888) 281-6531 for assistance.

Organizations are encouraged to call CARF toll free with any questions regarding which manual to use, which standards apply, interpretation of the standards, and clarification of the survey process. It is important to access CARF resources throughout the preparation process. Following is a list of CARF’s customer service units (CSUs) and the publications related to each.

<table>
<thead>
<tr>
<th>Customer Service Unit</th>
<th>Standards Manuals and Related Publications</th>
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<tbody>
<tr>
<td>Aging Services</td>
<td>■ Aging Services Standards Manual&lt;br&gt; ■ Aging Services Survey Preparation Workbook*&lt;br&gt; ■ Continuing Care Retirement Community Standards Manual&lt;br&gt; ■ Continuing Care Retirement Community Survey Preparation Workbook*&lt;br&gt; ■ Standards Manual Supplement for Networks**</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>■ Behavioral Health Standards Manual&lt;br&gt; ■ Behavioral Health Survey Preparation Workbook*&lt;br&gt; ■ Opioid Treatment Program Standards Manual&lt;br&gt; ■ Opioid Treatment Program Survey Preparation Workbook*&lt;br&gt; ■ Standards Manual Supplement for Networks**</td>
</tr>
<tr>
<td>Child and Youth Services</td>
<td>■ Child and Youth Services Standards Manual&lt;br&gt; ■ Child and Youth Services Survey Preparation Workbook*&lt;br&gt; ■ Standards Manual Supplement for Networks**</td>
</tr>
<tr>
<td>Medical Rehabilitation</td>
<td>■ Medical Rehabilitation Standards Manual&lt;br&gt; ■ Medical Rehabilitation Survey Preparation Workbook*&lt;br&gt; ■ Standards Manual Supplement for Networks**</td>
</tr>
<tr>
<td>Vision Rehabilitation Services</td>
<td>■ Vision Rehabilitation Services Standards Manual with Survey Preparation Questions&lt;br&gt; ■ Standards Manual Supplement for Networks**</td>
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*CARF recommends using the companion survey preparation workbook for your standards manual. The workbook assists in conducting a self-evaluation in preparation for the accreditation survey.

**Supplements for the standards manuals are available for download at: www.carf.org/Accreditation/QualityStandards/OnlineStandards.

**NOTE:** Standards manuals become effective on July 1, 2020, to allow organizations sufficient time to incorporate changes into their operations.
These accreditation policies and procedures relate to the site survey, accreditation process, and continuation of accreditation. Because all aspects of the accreditation process are reviewed regularly for appropriateness, these policies and procedures may be changed between standards manual publication dates. Notification of changes, additional information, and clarification can be obtained at the CARF website, www.carf.org, or by contacting CARF. Organizations that are currently accredited or have begun the process of becoming accredited and have obtained access to Customer Connect can obtain current accreditation policies and procedures at the Customer Connect website (customerconnect.carf.org).

NOTE: Customer Connect is CARF’s secure, dedicated website for accredited organizations and organizations seeking accreditation. Customer Connect is the primary means of transmitting certain documents, such as the survey fee invoice and quality improvement plan. These documents are posted to Customer Connect and an email is sent to the individual identified as the organization’s Survey Key Contact. Organizations should use Customer Connect regularly to view accreditation- and survey-related documents and to keep CARF informed of any changes in the name or email address of the key contact person.

The submission of a survey application constitutes the organization’s agreement to adhere to the CARF policies and procedures that are in effect on the date on which the survey application is submitted to CARF and to all subsequent changes as they become effective. The review and appeal process set forth in these policies and procedures, as amended from time to time, shall be the organization’s sole remedy with respect to the survey, accreditation decision, and continuation or termination of accreditation. By submitting the survey application, the organization expressly waives and releases CARF from any and all claims, demands, actions, lawsuits, and damages that may arise from or relate to, directly or indirectly, the survey, accreditation decision, and continuation or termination of accreditation.

Accreditation Conditions

The following Accreditation Conditions must be satisfied in order for an organization to achieve or maintain accreditation by CARF:

1. For a minimum of six months prior to the site survey, each program/service for which the organization is seeking accreditation must demonstrate:
   a. The use and implementation of CARF’s organizational and service standards applicable to the program/service.
   b. The direct provision of services to the persons served.

Intent Statements

This timeframe is required to ensure that the CARF survey process is not merely a paper review, but that the service seeking accreditation is actually having an impact on the persons served. In addition, this timeframe allows for the collection of sufficient historical data, information, and documentation to assess the organization’s conformance to the standards.

It is also expected that services will have been provided for at least six months prior to the site survey. This condition applies to organizations that have newly initiated program(s)/service(s) and to those that have ongoing program(s)/service(s) that are provided sporadically. Therefore, in the six months prior to the survey, the organization should have served at least one person in each service seeking accreditation. In a network, direct services are provided by its participants.
2. The organization must provide such records, reports, and other information as requested by CARF.

Intent Statements
It is the responsibility of the organization to provide evidence to the survey team to demonstrate conformance to the standards.

This condition also applies to information requested by CARF prior to, during, and after the site survey. The intent of this condition is for CARF to have access to all information deemed necessary to assess conformance to the standards. Access to stakeholders, including persons served, is also covered by this condition, as is access to all documents, including but not limited to files of persons served (active and closed), human resource files, strategic plans and reports, and financial statements. In certain circumstances, unavailability of key organizational staff necessary to demonstrate conformance to standards at the on-site survey may be grounds for Nonaccreditation.

3. A Quality Improvement Plan (QIP) must be submitted within 90 days following notice of accreditation. This plan shall address all recommendations identified in the report.

Intent Statements
CARF will provide the organization with the format to use for this plan with its notification of the accreditation decision.

If consultation in completing the QIP is needed, the organization is encouraged to contact CARF.

4. An organization that achieves a Five-Year Accreditation must submit a signed Annual Conformance to Quality Report (ACQR). The report is submitted in each of the years following the Accreditation.

Intent Statements
In order to maintain accreditation, organizations are expected to operate in conformance to CARF’s standards and comply with CARF’s policies and procedures on an ongoing basis. They must incorporate changes to the standards, accreditation conditions, and policies and procedures as they are published and made effective by CARF.

CARF will provide the organization with the format for this report, which must be completed and returned with the annual maintenance fee.

NOTE: If any of these conditions are not met, CARF will determine the appropriate course of action, which may include denial or withdrawal of accreditation.

Accreditation Decisions
To be accredited by CARF, an organization must satisfy each of the CARF Accreditation Conditions and demonstrate through a site survey that it meets the standards established by CARF. While an organization may not be in full conformance to every applicable standard, the accreditation decision will be based on the balance of its strengths with those areas in which it needs improvement.

CARF uses the following guidelines to determine each accreditation decision:

Five-Year Accreditation
The organization satisfies each of the CARF Accreditation Conditions and demonstrates substantial conformance to the standards. It is designed and operated to benefit the persons served. Its current method of operation appears likely to be maintained and/or improved in the foreseeable future. The organization demonstrates ongoing quality improvement and continuous conformance from any previous period of CARF accreditation.

Organizations must achieve accreditation as a CCRC to attain a Five-Year Accreditation.

There is fulfillment of ongoing and annual reporting requirements. At any time during the term of accreditation, CARF can proceed with conformance testing to determine ongoing conformance to standards, policies, and procedures.

Nonaccreditation
The organization has major areas for improvement in several areas of the standards; there are serious questions as to the benefits of services or the health, welfare, or safety of those served; the organization has failed over time to bring itself into substantial conformance to the standards; or the organization has failed to satisfy one or more of the CARF Accreditation Conditions.
Overview of the Steps to Accreditation

The table below provides an overview of the steps to accreditation. These steps are explained in more detail in the sections following the table.

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<tr>
<th>STEP 1</th>
<th>Consult with a designated CARF resource specialist.</th>
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<tr>
<td></td>
<td>An organization contacts CARF, and a resource specialist is designated to provide guidance and technical assistance.</td>
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<td></td>
<td>■ For an organization preparing for its first survey, it is important to make this contact early in the process. The resource specialist is available to answer questions in preparation for a survey and throughout the term of the accreditation.</td>
</tr>
<tr>
<td></td>
<td>■ For an organization preparing for a resurvey, the designated resource specialist may already be known. It is suggested that contact still be made early in the reaccreditation process to verify relevant organizational or program/service information.</td>
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<tr>
<td></td>
<td>■ The resource specialist provides the organization access to Customer Connect (customerconnect.carf.org), CARF’s secure website for transmitting documents and maintaining ongoing communication with accredited organizations and organizations seeking accreditation.</td>
</tr>
<tr>
<td></td>
<td>■ The organization orders the standards manual in which its program(s)/service(s) best fit. Visit <a href="http://www.carf.org/catalog">www.carf.org/catalog</a>.</td>
</tr>
<tr>
<td></td>
<td>■ The organization maintains ongoing contact with CARF for assistance.</td>
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<th>STEP 2</th>
<th>Conduct a self-evaluation.</th>
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<td></td>
<td>The organization conducts a self-study and evaluation of its conformance to the standards using the standards manual and its companion publication, the survey preparation workbook.</td>
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<td></td>
<td>The self-evaluation is part of the organization’s internal preparation process and is not submitted to CARF.</td>
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### STEP 3
Submit the survey application.

The organization submits the survey application via Customer Connect, customerconnect.carf.org.

- The survey application requests detailed information about leadership, program(s)/service(s) that the organization is seeking to accredit, and the service delivery location(s).
- The organization submits the completed survey application, required supporting documents, and a nonrefundable application fee (for original surveys only) at least three full calendar months before the two-month timeframe in which it is requesting a survey. Organizations undergoing resurvey submit their survey application on the date that corresponds with their accreditation expiration month (see page 12).
- The submission of the completed survey application indicates the organization's desire for the survey and its agreement to all terms and conditions contained therein.
- If any information in the survey application changes after submission, the organization should notify CARF immediately.

### STEP 4
CARF invoices for the survey fee.

After reviewing all information in the survey application, CARF invoices the organization for the survey fee. The survey fee invoice is posted to the Customer Connect website and an email notification is sent to the organization’s key contact person. Scheduling of the survey begins immediately upon invoicing. Any changes in problem dates must be communicated in writing to CARF by this time.

### STEP 5
CARF selects the survey team.

CARF selects a survey team with the appropriate expertise.

- Surveyors are selected by matching their program or administrative expertise and relevant field experience with the organization’s unique requirements.
- CARF notifies the organization of the names of team members and the dates of the survey at least 30 days before the survey.

### STEP 6
The survey team conducts the survey.

The survey team determines the organization’s conformance to all applicable standards on site through the observation of services, interviews with persons served and other stakeholders, and review of documentation.

- Surveyors also provide consultation to organization personnel.
- The organization is informed of the survey team’s findings related to the standards at an exit conference before the team leaves the site.
- The survey team submits its findings to CARF, but the team does not determine the accreditation decision.
- The organization pays expenses of surveyors.
<table>
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<th>STEP 7</th>
<th>CARF issues the accreditation decision.</th>
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<tr>
<td>CARF reviews the survey findings and issues one of the following accreditation decisions:</td>
<td></td>
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<tr>
<td>■ Five-Year Accreditation</td>
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<tr>
<td>■ Nonaccreditation</td>
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<tr>
<td>Approximately six to eight weeks after the survey, the organization is notified of the accreditation decision and receives a written report. The organization is also provided with a certificate of accreditation that lists the program(s)/service(s) included in the accreditation.</td>
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<tr>
<th>STEP 8</th>
<th>Submit a Quality Improvement Plan.</th>
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<td>Within 90 days after notification of accreditation, the organization fulfills an accreditation condition by submitting to CARF a Quality Improvement Plan (QIP) outlining the actions that have been or will be taken in response to all recommendations identified in the report.</td>
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<th>STEP 9</th>
<th>Submit all annual reporting materials.</th>
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<tr>
<td>An organization that achieves a Five-Year Accreditation submits a signed Annual Conformance to Quality Report (ACQR) to CARF on the accreditation anniversary date each year during the term of accreditation. This is a condition of accreditation.</td>
<td></td>
</tr>
<tr>
<td>■ CARF sends the organization the form for this report approximately ten weeks before it is due.</td>
<td></td>
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<tr>
<td>■ The ACQR reaffirms the organization’s ongoing conformance to the CARF standards.</td>
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<tr>
<td>■ A nonrefundable annual maintenance fee is submitted with the ACQR.</td>
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<tr>
<td><strong>Annual Financial Report with Ratio Pro</strong> Due 150 days after fiscal year-end date.</td>
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<tr>
<td>A CCRC that achieves a Five-Year Accreditation submits an Annual Financial Report, Ratio Pro spreadsheet, and audit to CARF within 150 days of the organization’s fiscal year end date in each of the years following the issuance of accreditation.</td>
<td></td>
</tr>
<tr>
<td>■ CARF sends the organization the form for this report approximately ten weeks before it is due.</td>
<td></td>
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<tr>
<td>■ The Financial Report, Ratio Pro spreadsheet, and audit is reviewed to confirm the organization’s ongoing conformance to the CARF standards.</td>
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<td>STEP 10</td>
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<tr>
<td>CARF maintains contact with the organization.</td>
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<tr>
<td>CARF maintains contact with the organization during the term of</td>
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<td>accreditation. Organizations should also contact CARF as needed to</td>
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<td>help maintain conformance to the standards and keep CARF informed of</td>
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<td>administrative or other items.</td>
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<tr>
<td>■ CARF offers publications to help organizations provide quality</td>
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<tr>
<td>program(s)/service(s).</td>
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<tr>
<td>■ CARF’s public website, <a href="http://www.carf.org">www.carf.org</a>, and its</td>
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<td>secure customer website, Customer Connect (<a href="http://customerconnect.carf.org">customerconnect.carf.org</a>), provide news, information, and resources.</td>
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<tr>
<td>■ CARF seminars and conferences are excellent ways to receive</td>
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<tr>
<td>updates and other information about the accreditation process and the</td>
<td></td>
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<tr>
<td>standards.</td>
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CARF Events

CARF sponsors a series of educational and training sessions to assist organizations to prepare for CARF accreditation, help them remain current with changes in the standards, present new standards, and discuss field practices. CARF also offers web-based educational events. To obtain the dates and locations of all events, visit www.carf.org/events or contact the Education and Training Department at (888) 281-6531, ext. 7114.

Steps to Accreditation

Step 1. Consult with a designated CARF Resource Specialist

The first step in the accreditation process is to contact CARF. When an organization contacts CARF, a dedicated resource specialist is assigned to provide guidance and technical assistance regarding the appropriate standards manual, program(s)/service(s) to be accredited, interpretation and application of standards, and accreditation process. The resource specialist is available to answer questions both in preparation for a survey and throughout the entire term of accreditation.

Step 2. Conduct a self-evaluation

To earn accreditation, an organization must meet Accreditation Conditions 1 and 2 and demonstrate that it meets the applicable CARF standards. The starting point is an assessment by the organization of its current practices against the applicable standards set forth in the appropriate standards manual. The organization conducts a self-study and evaluation of its conformance to the standards using the appropriate standards manual and its companion publication, the survey preparation workbook. Depending on the level at which the organization initially assesses its conformance, a number of successive assessments may be appropriate. The organization's designated resource specialist is available to provide free technical assistance during the self-evaluation process.

The self-evaluation is part of the organization’s internal preparation process, and there is no requirement for it to be submitted to CARF or shared with the surveyors. However, some organizations find it useful to share the self-evaluation with the survey team during the on-site survey.

Step 3. Submit the survey application

The survey application is completed and submitted online via Customer Connect. After preparing under the appropriate standards manual, an organization seeking accreditation for the first time requests access to the survey application for completion and submission to CARF. Resurvey organizations are notified of the survey application automatically. The survey application is submitted with the nonrefundable application fee when the organization is ready for survey dates to be established in accordance with the accompanying chart. It generally takes two to three months for a survey to be scheduled after the survey application has been received.

**Note:** The application fee is submitted only for original surveys.
Survey Timeframe At a Glance

An organization seeking accreditation for the first time uses the due date corresponding to its preferred timeframe.

Resurvey organizations use the due date corresponding to expiration month, not preferred timeframe. This lead time is needed for timely scheduling and issuing of a new decision before expiration of the current accreditation.

Please note that a survey application received after the due date is at risk for a delay in survey timeframe. Organizations are encouraged to submit their survey application at least ten business days before the indicated due date.

Submission of the completed survey application confirms the organization's agreement to all terms and conditions contained therein. If any information in the survey application changes after submission, CARF should be notified in writing immediately.

Selection of Program(s)/Service(s) to be Surveyed

In the survey application, the organization identifies the program(s)/service(s) it desires to have surveyed by CARF and the site(s) where they are provided, including administrative locations. The number and expertise of surveyors and the length of survey required are based on information in the survey application and will be determined at CARF's sole discretion. Additional information, such as the organization's budget, brochures, and other materials, must be sent to CARF when the survey application is submitted.

An organization has the right and responsibility to choose the program(s)/service(s) to be accredited. However, all locations that offer any of the program(s)/service(s) must be included in the accreditation. CARF will not accredit a program or service if only a portion of it is submitted for accreditation. For a CCRC, the CCRC program must be selected in this manual for a Five-Year Accreditation.

CARF does not consider the funding or referral entities as differentiating a program/service so as to exclude portions of it from being included in the accreditation. If the organization needs assistance in interpreting or applying this policy, it should contact CARF.

CARF may change the size and/or scope of any accreditation survey or decision as it deems appropriate.

Organizations with Multiple Program(s)/Service(s)

If one survey includes multiple program(s)/service(s) or sites for accreditation, and any one program/service or site is operating at a lower level of conformance to the standards than the others, the level of accreditation issued for that survey will be the level of the lowest-conforming program, service, or site.

An organization may submit more than one survey application if it wants to have separate surveys for different program(s)/service(s) or sites that it operates. In separate surveys, each accreditation decision is independent and based

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<th><em>Expiration Month</em></th>
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*CARF does not issue July expirations as the standards manuals become effective on July 1 of each year.

**CARF may request organizations with large surveys to submit their applications early.

NOTE: Actual survey timeframes are assigned by CARF based upon surveyor availability.
solely on the individual survey and the level of conformance demonstrated by the organization and the program(s)/service(s) that are part of that survey. In this case, different decisions may be issued as appropriate.

Step 4. CARF invoices for the survey fee

After reviewing the survey application, CARF invoices the organization for the survey fee. Organizations seeking accreditation as a Continuing Care Retirement Community also pay surveyor travel expenses related to the on-site survey. Surveyors will submit their expenses directly to CARF within seven days of the survey end date.

The survey fee must be paid in full within 30 calendar days of the invoice date. Any public agency for which advance payment of the survey fee is not legally permissible must submit, at least 30 days prior to the survey, a binding purchase order for the full amount of the survey fee.

CARF reserves the right to cancel any scheduled survey, or change the survey timeframe for any unscheduled survey, if the fee is not paid by the survey fee due date.

Once the surveyors are in transit to a survey site, the survey fee is not refundable in whole or in part. Thus, if a survey is terminated on site or is shortened for any reason, no portion of the survey fee will be refunded.

Please contact CARF for current fees.

Outstanding Debt

All survey and other fees referenced in this manual shall be paid when due. CARF will not accept a survey application from any organization that has an outstanding past due debt to CARF until that debt has been paid. CARF also reserves the right to withhold an accreditation decision or issue a Nonaccreditation if an outstanding debt remains. CARF may modify an organization’s existing accreditation, up to and including termination of accreditation, in the event any fees are not paid in a timely manner.

Step 5. CARF selects the survey team

Surveyors are assigned to surveys based on a number of factors, the most important of which is the surveyors’ experience with the types of program(s)/service(s) being surveyed. Other considerations include the availability of surveyors, language, and the need to avoid conflicts of interest.

The organization may request a change of any surveyor assigned to conduct the survey in the event of a bona fide conflict of interest.

CARF must receive the request for a surveyor change in writing within 14 calendar days of the date on which CARF transmits notification of surveyor assignment. A change in surveyor assignment is made when just cause, as determined by CARF, has been presented.

Subject to surveyor availability, the organization may be required to provide language interpreters at its expense to assist the surveyors; please contact CARF for details.

Scheduling the Survey Dates

Survey dates are established by CARF based on the survey application and in consultation with surveyors. A timeframe of no fewer than four weeks within a specific period of two consecutive months is required for scheduling. CARF must be advised at the time of submission of the survey application if there are days during the designated timeframe that will pose problems for the organization. Examples of such days may include community events, religious holidays, and vacation plans. A survey is scheduled during the organization’s workweek and hours of operation. The use of Saturdays and Sundays as survey days is limited to organizations that provide services on those days and only with prior approval from the organization.

Cancellation and Rescheduling

Best efforts are made to notify the organization of the specific survey dates at least 30 calendar days prior to the survey. An organization is considered scheduled for a site visit on the date the notification is sent. The dates established by CARF are final. A cancellation/rescheduling fee, plus all related nonrefundable travel cancellation
expenses, will be assessed if an organization requests any change affecting the scheduled dates or configuration of its survey, whether cancellation, postponement, or other date change, or if the survey is cancelled by CARF due to survey fees not timely paid.

It should be noted that CARF does not wait for receipt of the survey fee to schedule the survey. Therefore, to avoid a cancellation/rescheduling fee, the organization must notify CARF in writing of any changes in available survey dates prior to CARF’s notice of established dates.

When CARF is unable to schedule a survey in the designated timeframe, the organization’s current accreditation will not lapse but will be extended until notification of the next accreditation decision.

**Step 6. The survey team conducts the survey**

**Involvement of the Persons Served**

CARF considers the involvement of the persons served vital to the survey process. As such, persons served are involved in a variety of ways prior to, during, and after the survey.

Before the survey, persons served are notified of the pending survey and may submit comments about the organization’s performance and their satisfaction with services. During the survey, the organization identifies persons served for interview by the survey team; however, the surveyors may also select additional persons served in each program or service area for interviews.

Some of the persons interviewed may be those who contacted CARF prior to the survey. The surveyors may conduct some of the interviews in a focus group forum or via telephone. After the survey, the persons served are encouraged to continue to provide CARF with feedback about the services provided at any organization with accredited program(s)/service(s).

A person served is the preferred person to be interviewed. A family member, guardian, or significant other may, as appropriate, be interviewed instead of or in addition to a person served during the survey process. Community members, employers, and others may also be interviewed. All interviews are confidential.

**Before the Survey**

**Preparation**

In conjunction with the appropriate standards manual, the organization should use CARF’s other publications to adequately prepare for the site survey. Many of these publications have been written to help an organization prepare for a survey. CARF may be contacted by telephone or email to answer questions that the organization may have regarding the survey process or interpretation of the standards. Inquiries about the standards or survey process can be made as frequently as needed by an organization seeking accreditation, and there is no charge for this support.

During an original survey, the organization is expected to demonstrate, for standards that specify an activity be conducted on or within a specific time period (e.g., at least quarterly, at least annually), that the activity has occurred at least once within such period prior to the survey. During a resurvey, the organization is expected to demonstrate conformance to all applicable standards throughout the entire period since its last survey.

If an organization is a unit or department within a larger entity that develops and/or controls any policies, procedures, plans, or practices relevant to the survey, the organization should be prepared to demonstrate to the survey team how it and its program(s)/service(s) seeking accreditation implement such policies, procedures, plans, and practices.

**The survey poster**

At least 30 days prior to the survey, the organization must display a poster announcing the pending survey and the survey dates. This poster can be downloaded in various languages from the Resources section of Customer Connect (customerconnect.carf.org) in an editable format so that organizations may make adjustments (such as font, color, and size) to ensure the poster is accessible for all persons served. This poster must remain conspicuously posted at all locations until the survey concludes. Information on the poster includes a description of CARF as a review organization and instructions for
interested persons to contact CARF to submit comments about the organization’s performance and their satisfaction with services. These comments can be submitted through a toll-free phone number or via email, fax, or letter. Information received by CARF may be sent to the surveyors. The survey team may interview persons who have submitted comments or contacted CARF prior to the survey when on site. All interviews are confidential.

Pre-survey contact

Approximately three weeks before the visit, the survey team coordinator will contact the organization to discuss logistics and answer questions the organization may have regarding scheduling interviews and other items. The survey team may request that additional information that is not confidential be made available at the hotel the night before the survey or otherwise in advance. While provision of such information in advance of the survey is at the discretion of the organization, it can help facilitate an efficient and consultative on-site survey.

Assemble or arrange access to records

Records needed to substantiate conformance to the CARF standards should be assembled in one room of the organization to be available for surveyor use throughout the survey, or arrangements should be made for surveyor access to electronic records. Many of these items are listed as documentation examples in the survey preparation workbook.

Third-party representatives

Each organization is required to have at least one representative of a major purchaser or user of its services available, either in person or by phone, to be interviewed by the survey team. Although the organization generally chooses the individuals to be interviewed during the survey, the survey team may select other stakeholders to interview. An organization has the option of inviting third-party representatives to observe the orientation and exit conferences. Observations of interviews and survey team meetings, however, are prohibited because of the confidential nature of the matters discussed.

The Survey

**Note:** The daily schedule of a survey will vary for each organization. The following is only a sample.

First Day

Opening of business

The survey team arrives at the organization and conducts an orientation conference with the leadership, personnel, and others invited by the organization. The orientation conference provides the opportunity for the surveyors to clarify the purpose of the site survey, how the team will conduct the survey, and verify the program(s)/service(s) and sites to be surveyed. The organization should be prepared to provide the team with a brief overview of its operations, including the population served, the program(s)/service(s) provided, the programmatic objectives of the organization, and other important areas.

After the orientation conference

The survey team is given a brief tour of the physical facilities. Some team members may proceed directly to community sites that are a part of the survey rather than participate in the tour.

Mid-morning to late afternoon

The survey team meets to coordinate efforts and proceed with survey activities. The organization is asked to schedule interviews with any persons identified, based on their availability. Every effort is made to minimize disruption to ongoing operations. If the organization has any question about the scheduling of interviews, these should be addressed with the survey team coordinator.

With a short lunch break, the team spends the rest of the day observing the program(s)/service(s) being surveyed; interviewing various personnel, persons served, leadership, funding source representatives, community members, and others; and reviewing documents such as records of the persons served, fiscal reports, administrative records, and other materials.

Records for review shall be selected by the survey team. A responsible person from the organization should be on the premises at all times to facilitate the process and answer questions for the team; however, this person should not attend individual interviews or survey team meetings.
Evening

The survey team reviews findings relative to conformance to the standards. The surveyors may request permission to remove nonconfidential documents from the survey site for review in the evening. Approval of this is at the discretion of the organization. If the organization offers residential programs, community housing, or supported living services, evening hours may also be used to visit sites.

The work that the survey team must do in the evenings prior to the last day of the survey is quite extensive. Therefore, the organization should never schedule any social activity that would involve surveyors.

Second or Last Day

If the survey involves more than two days, the following schedule applies to the last survey day. The other day(s) will be used for further observation, interviews, and documentation review. It should be noted that the last day of the survey typically ends not later than 3:00 pm.

Opening of business

The survey team returns to the organization to obtain additional information, continue its interviews, review documents, and perform other survey activities. The organization's personnel may be asked for assistance in locating information to show conformance in specific areas.

Late Morning

The survey team meets to compile its findings and prepare for the exit conference. A pre-exit meeting may be requested with or by the personnel in charge to summarize the findings and/or discuss any areas still to be resolved.

Early Afternoon

The exit conference, which is approximately one hour in length, is conducted by the survey team with those invited by the organization. The organization may record the exit conference. The purpose of the conference is for the survey team to provide feedback concerning the strengths of the program(s)/service(s) and operations in relation to the standards, identify areas for improvement, and offer suggestions and consultation.

The organization may question any areas identified for improvement by the survey team at the exit conference, or immediately after the exit conference, and present further evidence of conformance to the standards before the surveyors leave the site. Once the survey team has left the site, the organization may not contribute any further information to demonstrate conformance to the standards.

NOTE: If any issues or questions arise before or during the survey that the organization cannot resolve with the surveyors, the organization is encouraged to call CARF for guidance and resolution prior to completion of the survey.

After the Survey

After the survey has ended, all questions or concerns should be directed to the CARF office rather than to members of the survey team.

Step 7. CARF issues the accreditation decision

The survey team reports its findings to CARF for review and determination of the accreditation decision. After the accreditation decision has been made, a written accreditation report is sent to the organization. The length of time from the site survey to the organization's notification of the decision is approximately six to eight weeks.

The report contains the accreditation decision and identifies recommendations for standards that were not fully met. When the organization is resurveyed, it is held accountable for follow up on the recommendations in the previous report and for evidence of conformance to standards throughout the term of accreditation, and for all applicable standards in the current standards manual.

NOTE: CARF personnel, acting during the course and within the scope of their employment, are the only persons authorized to officially represent CARF in interpreting its policies, procedures, standards, and accreditation conditions.
Step 8. Submit a Quality Improvement Plan

Within 90 days of notification of the accreditation decision, the organization submits to CARF a Quality Improvement Plan (QIP) in which it outlines the actions that have been or will be taken in response to the recommendations identified in the accreditation report. The QIP form with instructions is posted on Customer Connect (customerconnect.carf.org) at the time of the accreditation decision. CARF may be contacted for assistance if any recommendations require further explanation or if the organization needs assistance in determining whether its planned action is adequate to demonstrate conformance to the CARF standards. Submission of the completed QIP is required by Accreditation Condition 3 in order to maintain accreditation.

Step 9. Submit all annual reporting materials

As part of the commitment to ongoing performance excellence that all CARF-accredited organizations are expected to demonstrate, each organization that achieves a Five-Year Accreditation must submit an Annual Conformance to Quality Report (ACQR) in a format supplied by CARF for each year of its accreditation. The report is due to CARF on each anniversary date, along with the nonrefundable annual maintenance fee. Through the ACQR, the organization certifies that it at all times conforms to the standards, satisfies the Accreditation Conditions, and complies with CARF’s policies and procedures as changes are published and made effective from time to time.

Submission of the completed ACQR is required by Accreditation Condition 4 in order to maintain accreditation.

The Annual Financial Report and Ratio Pro

CARF monitors an organization’s financial strength and conformance to the CARF standards through the review of the Financial Report, Ratio Pro spreadsheet and audit. Please contact CARF if your organization needs assistance with the Ratio Pro tool.

Step 10. CARF maintains contact with the organization

Ongoing Communication of Administrative Items and Significant Events

During the term of accreditation, the organization must provide timely information to CARF about certain events that occur within or affect the organization or its accredited program(s)/service(s). Some situations may require further actions to be taken. (e.g., see the “Supplemental Surveys” and “Allegations, Suspensions, and Stipulations” sections.) Information about the events listed below must be communicated to CARF within 30 days of their occurrence:

- Change in leadership.
- Change in ownership (e.g., asset transfer, statutory merger, consolidation, or stock or membership transfer).
- Change in organization name.
- Change in mail and/or email address.
- Relocation, expansion, or elimination of an accredited program or location.
- Financial distress.
- Investigation.
- Material litigation.
- Catastrophe.
- Sentinel event.
- Bans on admission, fines, penalties, or other governmental sanctions.

Changes in ownership and/or leadership and the addition of a site to an existing accreditation, mergers, consolidations, joint ventures, and acquisitions involving accredited program(s)/service(s) may require the payment of an administrative fee or a supplemental survey.

Forms for reporting administrative items and significant events

Forms for reporting administrative items and significant events are available on the CARF website at www.carf.org/Accreditation/AccreditationProcess/OngoingCommunication and in the Resources section of Customer Connect (customerconnect.carf.org). Please contact CARF for more details.
Falsification of Documents

The information provided by an organization seeking CARF accreditation is a critical element in the accreditation process and in determining the organization’s conformance to the standards. Such information may be obtained via interviews or direct observation by surveyors or may be provided through documents reviewed by the survey team or submitted to CARF.

CARF presumes that each organization seeking accreditation is doing so in good faith and that all information is accurate, truthful, and complete. Failure to participate in good faith, including CARF’s reasonable belief that any information used to determine conformance to CARF’s standards during or subsequent to the survey has been falsified, may be grounds for Nonaccreditation or a decision to modify or withdraw the existing accreditation.

In the event that an organization loses accreditation or is not accredited because of CARF’s reasonable belief of falsification of documents or information, CARF will not accept a survey application from the organization for a period of at least twelve months. CARF may also notify the appropriate governmental agencies.

Public Information

Identification of Accreditation by the Organization

CARF accreditation is issued to an organization for identified program(s)/service(s). An organization that has achieved accreditation should identify this achievement publicly, and use of the CARF logo by an accredited organization for this purpose is encouraged. The CARF logo is available online in the Resources section of Customer Connect (customerconnect.carf.org) and on the CARF website at www.carf.org/logo. All references to CARF accreditation by the organization must clearly identify the accredited program(s)/service(s), unless all program(s)/service(s) offered by the organization are accredited by CARF.

CARF personnel and surveyors may not be referred to or quoted in any public release involving accreditation without prior approval from CARF. An organization may, however, disseminate or quote from the accreditation report.

Certificate of Accreditation

An organization is provided with one certificate of accreditation, which is suitable for framing. Additional certificates are available for purchase. This certificate identifies the organization that submitted the survey application, the level of accreditation, the program(s)/service(s) for which the organization is accredited, and the month and year in which the accreditation expires. For each year that an organization meets the annual requirements for continuing conformance, CARF will provide a seal to affix to the certificate indicating continued accreditation.

An organization may use or display its certificate of accreditation to demonstrate conformance to the CARF standards, but it may not use or display the certificate in any manner that is inconsistent with the purposes of CARF and its accreditation function or that misrepresents the availability or quality of the program(s)/service(s) offered by the organization. The certificate should never be used either explicitly or implicitly as a claim, promise, or guarantee of successful service. Accreditation indicates an organization’s demonstrated use of professionally approved standards and practices in connection with particular program(s)/service(s), and the certificate is regarded as providing information and guidance for the public at large and for persons considering services.

An accreditation applies only to the organization’s specific program(s)/service(s) surveyed by CARF. The certificate may be displayed only by that organization. If an organization closes one or more of its accredited program(s)/service(s) and other program(s)/service(s) remain accredited, the certificate should be returned to CARF and a revised certificate will be issued free of charge.

Upon dissolution of the organization or loss of accreditation for any reason, each unexpired
certificate must be returned to CARF and the organization must refrain from representing itself or its program(s)/service(s) as accredited and must cease to use or display the certificate or the CARF logo in any manner. Similarly, if accreditation is suspended, the organization must not represent itself or its program(s)/service(s) as accredited or use or display the certificate or the CARF logo until and unless accreditation is restored.

Release of Information by CARF
To enhance the value of accreditation to persons served and other stakeholders, CARF may release information related to an organization and its accreditation to the extent that it is not confidential or protected by law, including, but not limited to:

1. Whether CARF has received a survey application from a specific organization.
2. Scheduled survey dates for a specific organization.
3. Whether a survey has been completed.
4. The date of expiration of accreditation of a particular organization.
5. An organization's accredited program(s)/service(s).
6. An organization's accreditation decision and status.
7. Whether an organization has requested review of a Nonaccreditation decision.
8. Whether an organization is involved in appealing or may still appeal a Nonaccreditation decision.
9. As required by law or contract.

For convenient access to information, CARF includes on its website a searchable list of organizations with accredited program(s)/service(s), including identifying information such as name, address, and telephone number. This posting allows the public to review the accreditation status of an organization's accredited programs at any time.

Subsequent Surveys
Depending on the circumstances, CARF may conduct three types of surveys of the organization's programs following the initial survey. These survey types are described below.

Resurveys
To maintain accreditation beyond the expiration date of its current accreditation, an organization's program(s)/service(s) must be resurveyed or be in the process of a resurvey by the expiration date. CARF notifies an organization of the need for a resurvey approximately seven months before expiration of its accreditation.

The resurvey process is the same as the initial survey process in that a completed survey application is required and all applicable standards are applied. During a resurvey, however, the organization is expected to be able to demonstrate conformance during the entire period since its last survey. Also, special attention is given to implementation of changes made in response to the Quality Improvement Plan from the previous survey.

If new program(s)/service(s) are being added or the mission and focus of the organization or its program(s)/service(s) or locations have changed since the previous survey, it is suggested that the organization contact its CARF resource specialist.

Supplemental Surveys
The main objective of a supplemental survey is to recognize the dynamic status of organizations and permit changes in accreditation between surveys. Supplemental surveys may be required under two circumstances:

1. **When an organization changes its leadership or ownership or engages in a merger, consolidation, joint venture, or acquisition transaction.**

When an organization's leadership or ownership changes after the survey is conducted, it may be necessary to conduct a supplemental survey of conformance to the standards applicable to the organization's administration and program(s)/
service(s). For the same reasons, a supplemental survey may also be required when an organization is party to a merger, consolidation, joint venture, or acquisition involving accredited program(s)/service(s).

2. When an organization wishes to add a new program, service, or location to an existing accreditation.

An organization with currently accredited program(s)/service(s) may be required to have a supplemental survey for the purpose of adding a new location to its existing accreditation. CARF will determine the need for a supplemental survey once the organization notifies CARF, in writing, of the changes in the organization. CARF will contact a representative of the organization to get more details, if required.

A supplemental survey is always required if an organization wants to add a new program or service that is not currently accredited.

If a supplemental survey is required, the organization must submit a completed survey application to CARF and pay the associated survey fee.

The maximum term of the accreditation of the new program, service, or location added will be the remaining term of the current accreditation. If during the supplemental survey the program, service, or new location is found to be functioning at a lower level of accreditation than the program(s)/service(s) currently accredited, the result will be a reduction in the level and term of the entire accreditation decision.

A supplemental survey focuses on the program, service, or location being added. The standards that are applied may vary in accordance with the length of time since the previous survey. Organizations seeking to add a program, service, or location to their current accreditation should contact CARF for instructions regarding the applicable standards.

Monitoring Visits

CARF may conduct announced or unannounced monitoring visits of organizations with accredited programs/services. A monitoring visit may be conducted any time CARF receives information that an organization may no longer be conforming to the standards. The organization's accreditation may be modified as a result of a monitoring visit, and submission of a new Quality Improvement Plan may be required. A monitoring visit may consist of a partial or full survey team depending on the nature of the information received. The cost of a monitoring visit is covered by CARF.

Extension of Accreditation

Extensions of accreditation may be granted at CARF’s sole discretion. Any organization seeking an extension should submit its written request prior to timely submission of its resurvey application. While no request for extension will be approved prior to submission of the application, organizations are advised to contact CARF in advance for guidance regarding the likelihood that an extension will be granted under the circumstances. Extensions are generally not granted for more than three months.

Every extension request must include a sufficiently detailed explanation of the supporting rationale for CARF to give it reasonable consideration. Unless otherwise instructed by CARF, any request for an extension greater than three months must also include:

- Copies of the most recent performance analyses, as specified in Standards 1.N.1. and 1.N.2. in this manual.
- An update of the Quality Improvement Plan.
- Communication regarding any unreported administrative items or significant events required by these accreditation policies and procedures, if applicable.
- Letter from a funding agency or referral entity that supports the extension request, if appropriate.

If an extension is granted, only those program(s)/service(s) that are currently accredited and listed in the submitted resurvey application will be included in the extension. The resurvey following an extension will be conducted using the standards manual in effect on the date of the survey, and the expiration date issued will
typically reflect the original expiration month of the prior survey.

Organizations that submit a resurvey application or request for extension after the application due date risk a lapse in accreditation.

**Allegations, Suspensions, and Stipulations**

Upon being informed by any source of a change in an organization's conformance to the CARF Accreditation Conditions, standards, or policies and procedures, CARF, at its sole discretion, may review and modify the organization's accreditation status up to and including revocation of accreditation. CARF may also suspend or place stipulations on continued accreditation. During suspension, the organization is not accredited and may not communicate to third parties that it is CARF accredited.

CARF’s review may involve a request for an immediate response from the organization, the submission of documents and other information, solicitation of information from external organizations and individuals, and/or the undertaking of an announced or unannounced monitoring visit. Refusal to respond or unsatisfactory response to a CARF inquiry concerning an allegation may result in modification of accreditation status. When a change in status is deemed warranted, CARF will notify the organization of this action.

If an allegation is received after a survey but before the accreditation report and accreditation decision are released, CARF may withhold the release of the report and decision until such time as CARF may determine.

**Disputed Accreditation Decisions**

An organization issued a Nonaccreditation from an original survey, resurvey, or supplemental survey (“Survey”) may request an on-site review (“Review”).* Any Review is subject to the process set forth below for Review and Appeal of Nonaccreditation Decisions.

*If the accreditation decision is based on failure to satisfy one or more of the CARF Accreditation Conditions or unavailability of key organizational staff during the Survey, as determined in CARF’s sole discretion, the accreditation decision is final and the review and appeal processes do not apply.

**Review and Appeal of Nonaccreditation Decisions**

**Review**

1. **Request for Review.** CARF must receive a written request for a Review from the organization (“Request”) within 30 calendar days of the date of the letter that communicates the accreditation decision from the Survey.

2. **Review Fee.** CARF shall determine the number of surveyors and days for the Review and issue an invoice for the nonrefundable Review fee, which is equal to CARF’s current survey fee. The fee is due and payable by the organization within ten calendar days of the invoice date.

3. **Scheduling.** Following payment of the Review fee, CARF shall contact the organization to obtain days to avoid in scheduling. CARF shall make reasonable efforts to schedule the Review within 60 calendar days of receipt of payment. Once scheduled, CARF shall notify the organization of the date(s) of the Review and the assigned survey team.

4. **On-Site Review.** The Review shall be conducted using the standards applied on the Survey. The Review survey team shall conduct interviews, review documents, and otherwise gather information to determine findings as of the date(s) of the Review (“Findings”); however, it is the responsibility of the organization to provide information to the survey team that demonstrates conformance to the applicable standards. A Review is intended to be a full survey; accordingly, all standards applied on the Survey may be applied on the Review.

5. **Accreditation Decision.** CARF shall issue an accreditation decision, with or without stipulations, based on its on-balance consideration of the Findings.
6. Miscellaneous. If CARF does not timely receive a Request or full payment of the Review fee, such shall constitute the organization's knowing and intentional waiver of this review process. All CARF Accreditation Policies and Procedures are applicable to this review process to the extent not inconsistent herewith. The Findings, accreditation decision, and all other matters related to the Review, are final; provided, however, that if the result of the Review is Nonaccreditation, the organization may be entitled to appeal pursuant to the process set forth below. All decisions and determinations related to and interpretations of this review process shall be determined at CARF’s sole and binding discretion.

**Appeal**

1. Notice of Appeal. An organization issued a Nonaccreditation from a Nonaccreditation Review is entitled to a hearing before an appeal panel (“Panel”) if CARF receives written notice of appeal from the organization (“Notice”) within ten calendar days of the date of the letter that communicates the accreditation decision from the Review. The sole issue on appeal shall be whether the Review was conducted in a manner consistent with CARF’s published review process; that is, whether the Review survey team conducted interviews, reviewed documents, and otherwise gathered information to determine Findings (“Issue”).

2. Materials and Election. CARF must receive from the organization within ten calendar days of the Notice date: (a) all written materials it shall present at the hearing (“Materials”) or a written statement that no materials shall be presented (“Statement”); and (b) a written election to conduct the hearing either by telephone or in person at CARF headquarters in Tucson, Arizona, U.S.A. (“Election”).

3. Scheduling. Following receipt of the Materials or Statement and the Election, CARF shall contact the organization to obtain days to avoid in scheduling. CARF shall make reasonable efforts to schedule the hearing within 60 calendar days of receipt of the Materials or Statement and the Election. Once scheduled, CARF shall notify the organization of the date of the hearing and the designated Panel.

4. Appeal Hearing. During the hearing, the organization shall have up to one hour to present the previously submitted Materials, if any, and any unwritten information it believes support a determination that the Review survey team did not conduct interviews, review documents, and otherwise gather information to determine Findings. Thereafter, the Panel may pose questions to the organization and to the Review survey team. Finally, the organization shall have up to 20 minutes to provide any concluding remarks. The organization and survey team shall not question each other.

5. Irrelevant Information. Any information deemed irrelevant to the Issue may be excluded from the hearing and/or not considered by the Panel. The Panel shall under no circumstances consider the Findings.

6. Accreditation Decision. CARF shall affirm the Nonaccreditation or issue another accreditation decision, with or without stipulations, based on consideration of the relevant information received by the Panel at the hearing.

7. Miscellaneous. If CARF does not timely receive Notice, the Materials or Statement, or the Election, or if the organization fails to present relevant information at the scheduled hearing, such shall constitute the organization’s knowing and intentional waiver of this appeal process. The accreditation decision and all other matters related to the appeal are final and not subject to review or appeal. All decisions and determinations related to and interpretations of this appeal process shall be determined at CARF’s sole and binding discretion.
The purpose of this section is to identify notable changes that have been made in the standards in this manual compared to the previous year’s manual. Please be aware that some standards may have minor revisions that do not change the requirements of the standard and are not listed here.

In addition to the changes noted in this section, throughout the manual the Intent Statements, Examples, Resource listings, and other supporting content have been revised and updated to remain current and/or to clarify the intent or requirements of the standards. Changes in the Accreditation Policies and Procedures, program descriptions, applicable standards information, and reference materials are also not listed here.

**NOTE:** CARF makes every effort to list all significant changes in the standards; however, not all changes are included. All sections that are applicable to an organization should be thoroughly reviewed to ensure that the current standards are implemented in the organization’s accredited programs and services and those seeking accreditation.

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### Section 1. ASPIRE to Excellence®

#### 1.A. Leadership
- In Standard 1.A.3., element k. has been modified to require *ongoing review of the organization’s policies in accordance with organizational needs.*
- In Standard 1.A.5., element b.(8) is new.

#### 1.B. Governance
- Standard 1.B.5. has been revised and restructured.

#### 1.C. Strategic Planning
- In Standard 1.C.1., element g. has been changed from *Service area needs* to *Social determinants of health.*

#### 1.F. Financial Planning and Management
- Standard 1.F.5. is new; subsequent standards were renumbered accordingly.
- Previous Standard 1.F.9. has been moved and renumbered to 1.F.11.
- In Standard 1.F.21. (was 1.F.20.), previous element d. has been restructured to two separate elements, now d. and e. Requirements are not changed.

#### 1.G. Risk Management
- Standard 1.G.4. has been modified to specify that reviews of contract services be *documented.*

#### 1.H. Health and Safety
- In Standard 1.H.7., elements c.(2) and c.(3) have been revised and element c.(5) is new.
- Standard 1.H.8. is new; subsequent standards were renumbered accordingly.
- In Standard 1.H.10. (was 1.H.9.), element f.(18) is new.
- In Standard 1.H.11. (was 1.H.10), elements b.(3), b.(5), and b.(6) are new and b.(4) has been revised; subsequent elements were renumbered accordingly.
- Standard 1.H.15. (was 1.H.13.) has been moved and renumbered accordingly.
- The stem of Standard 1.H.16. (was 1.H.15.) has been modified slightly for clarity.

#### 1.J. Technology
- In Standard 1.J.1., element a.(6), *Assistive technology*, is new.
- In Standard 1.J.2., previous element e. has been restructured to two separate elements, now e. and f. Requirements are not changed.
- In Standard 1.J.4., elements b.(3) and b.(5) have been revised and element b.(4) is new.
1.K. Rights of Persons Served
■ In Standard 1.K.4., elements b.(4) and b.(6) have been revised and element b.(5) is new.

1.M. Performance Measurement and Management
■ The standards in this section have been revised and updated in their entirety based on input from the field.

1.N. Performance Improvement
■ The standards in this section have been revised and updated in their entirety based on input from the field.

Section 2. Care Process for the Persons Served

2.A. Program/Service Structure
■ The standards in this section have been revised and reorganized. Standards that apply to programs that served any persons with dementia and are not seeking accreditation as a Dementia Care Specialty Program have been moved to new Section 2.C., and standards for Skin Integrity and Wound Care have been moved to new Section 2.D.
■ In Standard 2.A.1., the stem of element b. has been modified slightly for clarity.
■ In Standard 2.A.13., element a.(17) is new.
■ Standard 2.A.26. is new and requires a policy that addresses the use of chemical and physical restraints.
■ Standard 2.A.27. is new and requires written procedures that address the use of chemical and physical restraints.

2.B. Residential Communities
■ The title of this section has been changed.

2.C. Care Process for Specific Diagnostic Categories
■ This section is new in the 2020 manual and contains standards for programs that serve any persons with dementia and are not seeking accreditation as a Dementia Care Specialty Program. These standards were previously in Section 2.A. The standards have also been revised and reorganized.

2.D. Skin Integrity and Wound Care Standards
■ This section is new in the 2020 manual and contains standards for skin integrity and wound care that were previously included in Section 2.A. The standards in this section have also been revised and reorganized.

Section 3. Program Specific Standards

3.A. Adult Day Services
■ In Standard 3.A.3., element a. has been revised for clarity.
■ Previous Standard 3.A.4. has been deleted; subsequent standards were renumbered accordingly.
■ Previous Standard 3.A.7. has been deleted; this concept is now addressed in Standards 2.A.26. and 2.A.27. Subsequent standards were renumbered accordingly.

3.C. Person-Centered Long-Term Care Community
■ Previous Standard 3.C.19. has been deleted; this concept is now addressed in Standards 2.A.26. and 2.A.27. Subsequent standards were renumbered accordingly.
■ In Standard 3.C.23., previous element b.(17) has been deleted.

3.D. Home and Community Services
■ In Standard 3.D.5., previous elements h. and i. have been deleted and subsequent elements were renumbered accordingly. These concepts are now addressed in new Standard 1.H.8.

Section 4. Specialty Population Designations

4.A. Dementia Care Specialty Programs
■ Standard 4.A.2. was previously 4.A.14. and some elements have been reorganized; subsequent standards were renumbered accordingly.
■ In Standard 4.A.3. (previously 4.A.2.), element a. has been changed from History to Life history, and previous element b. was deleted; subsequent elements were renumbered accordingly.
Changes in the 2020 Manual

- In Standard 4.A.4. (previously 4.A.3.), element c.(1)(a) is new; subsequent elements were renumbered accordingly.
- Previous Standard 4.A.5. has been deleted from this section; this concept is now addressed in Standards 2.A.26. and 2.A.27. Subsequent standards were renumbered accordingly.
- Previous Standard 4.A.14 has been moved and renumbered to Standard 4.A.2.
- In Standard 4.A.14. (previously 4.A.15.), element b.(14)(a) was changed from History to Life history, and previous element b.(14)(b) has been deleted; subsequent elements were renumbered accordingly.

Glossary

The following term has been added:

- Implement

The definitions of the following terms have been modified:

- Investigation
- Personnel
- Sentinel event
SECTION 1

ASPIRE to Excellence®

ASPIRE to Excellence® is a framework of standards introduced by CARF that specifically addresses business practice quality improvement.

This quality framework focuses on integrating all organizational functions while effectively engaging input from all stakeholders, including persons served. It provides a logical, action-oriented approach to ensure that organizational purpose, planning, and activity result in the desired outcomes.

Using these standards will help an organization’s ability to identify and implement change and to maintain sustainability. The standards are organized into the following areas:

Assess the Environment. Environmental assessment and analysis are necessary to guide all organizational planning and action. Assessments are conducted within the context of an organization’s location; sphere of influence; and purpose, vision, and mission. Social, economic, competitive, legal, regulatory, and political environments in which an organization operates are also evaluated. The role of leadership is critical to environmental assessment.

Set Strategy. Setting strategy means recognizing organizational competencies, identifying opportunities and threats, and articulating a high-level plan to sustain and advance an organization’s purpose. Strategy translates the environmental assessment factors into usable planning assumptions, sets goals and priorities, and aligns resources to achieve performance targets.

Persons Served and Other Stakeholders—Obtain Input. This input process engages all stakeholders to promote long-term organizational excellence. In a service environment, organizational success cannot be achieved or sustained without success for the persons served. Actively engaging the persons served as part of the planning and service processes has been demonstrated to result in better outcomes.

Implement the Plan. Implementation means translating strategic goals into tangible action. Sound implementation requires a solid foundation of service delivery, business practices, and organizational resources—including personnel, technology, and assets.

Review Results. Setting specific, measurable goals and indicators allows an organization to track its performance and outcomes. Appropriate personnel and stakeholders must review and analyze results in order to determine areas for improvement. These activities position an organization to develop and initiate quality improvement changes.

Effect Change. Effecting change means translating the results analysis into focused actions. An organization may renew or revise its strategy and tactics to improve performance against targets. Achieving excellence requires disciplined continuous improvement.
Assess the Environment

A. Leadership

Description
CARF-accredited organizations identify leadership that embraces the values of accountability and responsibility to the individual organization’s stated mission. The leadership demonstrates corporate social responsibility.

1.A. The organization identifies:
   a. Its leadership structure.
   b. The responsibilities of each level of leadership.

Examples
The leadership structure can be documented in the form of an organizational chart, table of organization, or narrative description of the positions and lines of authority within the organization. Responsibilities of leadership might be described in job descriptions, bylaws, policies, or narrative descriptions.
The survey team verifies that whoever is identified fulfills the responsibilities of leadership. This may be done by interviews with boards, councils, and management teams; by review of minutes of meetings; and by observation.

1.A. 2. A person-centered philosophy:
   a. Is demonstrated by:
      (1) Leadership.
      (2) Personnel.
   b. Guides the service delivery.
   c. Is communicated to stakeholders in an understandable manner.

Intent Statements
The organization’s person-centered philosophy should be evident in the development and delivery of services, systems, approaches, and interventions. Implementation of this philosophy from the unique perspectives of the leadership, personnel, and persons served is addressed during the survey process.
See the Glossary for the definition of stakeholders.

Examples
Exploring the normal pattern of the day of a person served to best meet program scheduling.
Recognizing unique aspects of the person served and how these might be incorporated into the programming; for example, active in the community, religious, or social agencies; active volunteer, worker, leader of a group.
2.c. The person-centered philosophy could be communicated a number of ways, including:
   ■ Posting it on the walls or website of the organization.
   ■ Incorporating it into materials that are distributed to stakeholders, such as orientation handbooks for the persons served and their families, personnel, volunteers, and advisory and governing boards; fact sheets, plans, and performance reports; and marketing brochures and pamphlets.
   ■ Articulating it during tours of the organization; presentations, such as orientation and training for personnel, volunteers, and advisory and governing boards; community education sessions; meetings and forums to seek input from stakeholders; and recorded messages, such as the voice response system.

1.A. 3. The identified leadership guides the following:
   a. Establishment of the:
      (1) Mission of the organization.
      (2) Direction of the organization.
   b. Promotion of value in the programs and services offered.
c. Achievement of outcomes in the programs and services offered.
d. Balancing the expectations of the persons served and other stakeholders.
e. Financial solvency.
f. Risk management.
g. Ongoing performance improvement.
h. Development of corporate responsibilities.
i. Implementation of corporate responsibilities.
j. Compliance with:
   (1) All legal requirements.
   (2) All regulatory requirements.
k. Ongoing review of the organization’s policies in accordance with organizational needs.
l. Health and safety.
m. Succession planning.
n. Strategic planning.
o. Technology planning.

Intent Statements

3.k. Review of the organization’s policies addresses all policies specific to the program(s) seeking accreditation and policies that directly relate to or impact the program(s). Through an ongoing systematic review of its policies an organization can address in real time the relevance, pertinence, and necessity of existing policies as well as the need for updates or new policies to guide its operations and practices.

3.m. Succession planning identifies actions to be taken by the organization should key personnel be unavailable to perform their duties due to retirement, resignation, serious illness, death, or other reasons. Succession planning may be formal or informal depending on the needs of the organization. See Standards 1.I.3.g. and 1.I.11. in Section 1.I. Workforce Development and Management.

3.o. The leadership is actively engaged in planning related to the organization’s implementation of technology systems and solutions that support and enhance its business and service delivery practices.

Examples

The delegation of activities, the feedback and collaboration of various levels of the leadership, and the checks and balances that the leadership has created are evident. This may be observed; heard in interviews; or read in minutes, reports, and orientation materials for boards and management.

3.m. Succession planning might identify which employees within the organization could move into key positions, consider how to develop employees to fill leadership positions, and highlight the need or opportunity to identify potential leaders external to the organization or even external to the field.

1.A. 4. The leadership of the organization is accessible to:
   a. Persons served.
   b. Personnel.
   c. Other stakeholders.

1.A. 5. The organization implements a cultural competency and diversity plan that:
   a. Addresses:
      (1) Persons served.
      (2) Personnel.
      (3) Other stakeholders.
   b. Is based on the consideration of the following areas:
      (1) Culture.
      (2) Age.
      (3) Gender.
      (4) Sexual orientation.
      (5) Spiritual beliefs.
      (6) Socioeconomic status.
      (7) Language.
      (8) Other factors, as relevant.
   c. Is reviewed at least annually for relevance.
   d. Is updated as needed.

Intent Statements

The organization demonstrates an awareness of, respect for, and attention to the diversity of the
people with whom it interacts (persons served, personnel, families/caregivers, and other stakeholders) that are reflected in attitudes, organizational structures, policies, and services. The organization's cultural competency and diversity plan addresses how it will respond to the diversity of its stakeholders as well as how the knowledge, skills, and behaviors will enable personnel to work effectively cross culturally by understanding, appreciating, and respecting differences and similarities in beliefs, values, and practices within and between cultures.

Examples

The organization assesses and has awareness and knowledge of the diversity of a variety of stakeholders. Examples of diversity awareness and knowledge include areas such as spiritual beliefs, holidays, dietary regulations or preferences, clothing, attitudes toward impairments, language, and how and when to use interpreters. The organization should be prepared to discuss what has resulted from the knowledge gained; e.g., modified service delivery, consideration of diversity in person-centered plans, personnel training, increased satisfaction of stakeholders.

In developing a cultural competency and diversity plan, an organization looks at the diversity of its community; internal and external stakeholders; and potential changes in demographics to be proactive in education, training, and service delivery. To facilitate the culturally competent organization, the plan might include areas such as recruitment efforts for personnel, modification of educational materials for persons served and family/support systems, support for training and education of personnel, or incorporation of spiritual beliefs into service delivery options.

Training programs are designed to develop awareness and sensitivity, and training specific to the diversity of the local community would be included. An organization would look at the cultural and spiritual makeup of its community to note what applies in the organization and train personnel on that. Diversity in terms of culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status, and language would be addressed. Knowledge of cultural and spiritual diversity is a critical component when providing respectful and individualized quality services/supports. Individualized service plan development includes consideration of a person's cultural, spiritual, and economic background. Part of the benefit of this is understanding the things that make relationships with people in other cultures easier or more difficult. Issues may be as simple as food preferences but can include spiritual beliefs, holidays, language, how/when to get interpreters, and clothing.

Surveyors will look for the assessment and knowledge of diversity issues. Examples of how this might be demonstrated include:

- Educational events.
- Training on special needs.
- Films and lectures.
- Service modification.
- “Open door” discussion groups.
- Satisfaction surveys.
- Variety of events and activities.

5.b.(3) Gender may include both gender identity and gender expression.

Resources

The Society for Human Resource Management has information about diversity training on its website at www.shrm.org that might be helpful, including views of disability and its causes, and the influence of culture on service delivery and predicted outcomes.

Many other professional, educational and advocacy organization websites provide information related to diversity and cultural competency. These include:

- National Center for Cultural Competence: nccc.georgetown.edu
- U.S. Department of Health and Human Services Think Cultural Health: www.thinkculturalhealth.hhs.gov
- Human Rights Campaign: www.hrc.org/resources
Section 1.A. Leadership

- Indigenous Cultural Safety Collaborative Learning Series: www.icscollaborative.com
- Centres for Learning, Research & Innovation in Long-Term Care; Supporting Diversity and Inclusion: https://clri-ltc.ca/diversity

1.A. 6. Corporate responsibility efforts include, at a minimum, the following:
   a. Written ethical codes of conduct in at least the following areas:
      (1) Business.
      (2) Marketing.
      (3) Contractual relationships.
      (4) Conflicts of interest.
      (5) Use of social media.
      (6) Service delivery, including:
         (a) Exchange of:
            (i) Gifts.
            (ii) Money.
            (iii) Gratuities.
         (b) Personal fundraising.
         (c) Personal property.
         (d) Setting boundaries.
         (e) Witnessing of legal documents.
      (7) Professional responsibilities.
      (8) Human resources.
      (9) Organizational fundraising, if applicable.
      (10) Prohibition of:
         (a) Waste.
         (b) Fraud.
         (c) Abuse.
         (d) Other wrongdoing.
   b. Written procedures to deal with allegations of violations of ethical codes, including:
      (1) A no-reprisal approach for personnel reporting.
      (2) Timeframes that:
         (a) Are adequate for prompt consideration.
         (b) Result in timely decisions.
   c. Education on ethical codes of conduct for:
      (1) Personnel.
      (2) Other stakeholders.
   d. Advocacy efforts for the persons served.
   e. Corporate citizenship.

Intent Statements

Corporate responsibility demonstrates what an organization stands for, including its ethical, social, and environmental values. It involves creating, communicating, and balancing value for all stakeholders.

Corporate responsibility assists in:
- Advocating for the persons served.
- Promoting ethical business practices.
- Developing efficiency as an organization.
- Considering the impact of organizational activities on persons served, personnel, other stakeholders, and the environment.

Examples

6.a. The codes of ethical conduct could be developed using information from such sources as state practice acts for the various disciplines/professions involved in services; the ethical codes of professional associations for the various disciplines/professions involved in services; the ethical codes of business, marketing, human resources management associations and organizations that evaluate charities; and the organization's own mission and core values statements and corporate compliance programs.
6.a.(4) Examples of conflicts of interest might include:
- Referral fees, self-referrals, and fee splitting.
- Accepting gifts or money from a vendor who does or is trying to secure business with the organization.
- Preferential treatment of an individual or entity due to a personal relationship with someone in the organization.
- Use of confidential information for one’s own advantage.
- Employment by more than one organization resulting in competing interests.
- A board member who also serves on the board of a competitor organization.

6.a.(5) This standard relates to Standard 1.G.3. on media relations and social media in the context of risk management. With the ubiquity of social media, it is increasingly important that organizations address related risks and ethical considerations as part of their codes of conduct. Topics an organization might address include acceptable use of social media by personnel as it relates to the organization, such as posts that positively reflect on the organization and its activities; privacy and confidentiality considerations, such as seeking permission from persons served for posts or pictures that include them and not sharing information about persons served in personal posts; how an organization’s social media will be monitored for adherence to its expectations and how violations will be dealt with; and engagement on social media during work hours. Additionally, the organization may address how it uses social media searches as part of its applicant vetting process.

6.a.(6)(b) Examples of personal fundraising that may be addressed in an organization’s written code of ethical conduct include personnel soliciting funds on behalf of a personal cause, selling cookies for a daughter in Girl Scouts, selling candy or wrapping paper for a child’s school, persons served selling items on behalf of the organization, and allowing persons served to raise funds by appeals to personnel or other persons served.

6.a.(6)(c) Ethical conduct might include respect for and safeguarding of the personal property of the persons served, visitors, and personnel and property owned by the organization.

6.a.(6)(d) The code of ethical conduct might address relationship issues, such as personnel dating other personnel or persons served, sexuality, and boundaries in the relationships between providers and the persons served.

6.a.(6)(e) Examples of legal documents that personnel may be asked to witness include powers of attorney, guardianship, and advance directives.

6.b. An organization could use a mechanism such as an ethics committee to investigate and act on allegations of violations of ethical conduct.

6.d.–e. Examples of advocacy and corporate citizenship efforts could be:
- Positions on local boards that address accessibility, housing, leisure pursuits, and employment for persons in need of human services.
- Educational events for communities on caregiver issues.
- Educational events for schools on safety issues, such as wearing helmets while riding bikes.
- Drug and alcohol programs.
- Education on health issues.
- Employment opportunities.
- Active involvement in community organizations and service groups, such as chambers of commerce, rotary clubs, governor councils, advisory committees, and meals on wheels.
- Providing reasonable accommodations to promote equal opportunities for participation throughout all levels of the organization.
- Providing access or referral to social, legal, or economic advocacy resources.
- Involvement in projects and programs to inform, educate, protect and promote a healthy and sustainable environment, such as recycling, use of environmentally friendly products, reduction of consumption in the areas of water and energy, or reduction of greenhouse gas emissions.
1.A. 7. An organization in the United States receiving federal funding demonstrates corporate compliance through:
   a. Implementation of a policy on corporate compliance that has been adopted by the organization's leadership.
   b. Implementation of written procedures that address exclusion of individuals and entities from federally funded healthcare programs.
   c. Designation of a staff member to serve as the organization's compliance officer:
      (1) That is documented.
      (2) Who:
         (a) Monitors matters pertaining to corporate compliance.
         (b) Conducts corporate compliance risk assessments.
         (c) Reports on matters pertaining to corporate compliance.
   d. Training of personnel on corporate compliance, including:
      (1) Role of the compliance officer.
      (2) The organization's procedures for allegations of fraud, waste, abuse, and other wrongdoing.
   e. Internal auditing activities.

Intent Statements
The acceptance of federal funding requires acceptance of the responsibility and accountability for tracking the funds and determining and overseeing how funds are being used and reported. Receiving federal funding includes direct and indirect federal funding. The receipt of federal funding may occur in a variety of ways, including, but not limited to, the direct receipt of Medicaid or Medicare funding, funding through another entity (such as a block grant or funds received through a vocational rehabilitation or other state agency contract), or funding through being a federally funded network.

7.b. The Office of Inspector General has the authority to exclude individuals and entities from federally funded healthcare programs.

Hiring an individual or entity on the List of Excluded Individuals/Entities (LEIE) may subject an organization to monetary penalties. Written procedures address the organization's process and timeframes for verifying that personnel are not on the LEIE and actions to be taken in response to the information received. For further information, see https://oig.hhs.gov/exclusions/index.asp.

7.e. Internal auditing activities include audits that would reasonably uncover improper conduct and/or billing errors.

Examples
Under corporate compliance systems, organizations develop and implement processes to assess compliance issues, take corrective measures, and continually monitor compliance in all areas including administration and service provision. Generally, the term compliance is used to describe the act of complying with or acting in accordance with a set of standards or expectations mandated by an outside entity and is frequently used in conjunction with regulatory reviews, licensing audits, etc.

The organization, by assigning an individual to ensure that these business practices are followed, demonstrates that it can be a responsible agent. With these responsibilities, the organization is committed to protecting its personnel when actions of the organization are being put under scrutiny. Personnel will be given assistance during any investigative process.

A corporate compliance program must be “effective” as defined by the U.S. sentencing guidelines and be “…reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal conduct.” Perhaps the most practical benefit of having an effective corporate compliance program in place is the mandatory reduction in any monetary fines and penalties ordered by a judge who imposes a sentence on an organization. The implementation of a corporate compliance program establishes an atmosphere that prompts early detection of any wrongdoing before it becomes too serious and/or before it is detected through a regulatory or governmental audit or survey.
Additional benefits of an effective corporate compliance program are:

- Reducing the likelihood of a violation occurring.
- Reducing the likelihood of civil liability, which comes chiefly in the form of demands for return of overpayments, civil money penalties, and whistle-blower lawsuits.
- Providing management with a different and generally more accurate view of the organization.
- Establishing a structure of information relevant to the compliance program.
- Establishing a structure to maximize the right of confidentiality under the attorney-client privilege.

7.a. A policy on corporate compliance typically articulates the organization’s strong ethical culture and commitment to compliance with all applicable laws, regulations, and requirements. The role of the compliance officer may be defined, including the compliance officer’s access to top-level leadership and/or the governing board.

7.c.(2)(a) The compliance officer may perform compliance-related activities or monitor activities delegated to other personnel.

7.c.(2)(b) Compliance risk assessment activities can be included in the organization’s risk management activities.

7.c.(2)(c) The compliance officer reports to top-level leadership regarding compliance-related activities; results of internal auditing activities; and results of investigations from reports of suspected fraud, waste, and abuse from organizational personnel.

7.e. The internal auditing activities should be designed to evaluate the organization’s compliance with federal requirements as well as determining the effectiveness of the compliance program.

8. Leadership provides resources and education for personnel to stay current in the field in order to demonstrate program strategies and interventions that are based on accepted practices in the field and current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.

Intent Statements
Leadership support is critical to the ability of personnel to learn and implement current strategies and interventions.

Examples
Examples of resources that leadership might provide include journal subscriptions, online access to learning opportunities and reference materials or journals, guest speakers, sponsoring educational events at the organization, inservice programs, journal clubs, collaborative resource or education efforts with other area providers of services, financial support, and/or time off to participate in special interest groups or to attend conferences.

Applicable Standards
Standard 1.A.9. applies to organizations that directly solicit charitable financial support in connection with any program seeking accreditation. It does not apply to organizations whose fundraising is conducted by a foundation, third party, or other separate legal entity, or in connection with programs not seeking accreditation.

1.A. 9. To demonstrate accountability, an organization that engages in fundraising:

a. Implements written procedures that address, at a minimum:

(1) Oversight.

(2) Donor:

(a) Solicitation.

(b) Communication.

(c) Recognition.

(d) Confidentiality.

(3) Valuing of donations.

(4) Use of donations in accordance with donor intent.
Section 1.A. Leadership

(5) Documentation and recordkeeping.

(6) Use of volunteers in fundraising efforts, if applicable.

b. Provides training related to fundraising written procedures to appropriate personnel, including:

(1) Initial training.

(2) Ongoing training.

Intent Statements

To aid in success of fundraising initiatives, many individuals and organizations want to direct funds with confidence toward programs and organizations that demonstrate well-managed fundraising efforts. Organizations may engage in fundraising endeavors using various solicitation approaches such as letters, phone calls, email, social media, or in-person events. To reduce risk and ensure the integrity of its fundraising programs, it is important that organizations establish and assign responsibility and authority for their fundraising functions and activities.

9.a.(2) Engaging donors is key to an organization's fundraising efforts. A variety of mechanisms allow an organization to reach and establish relationships with donors based on their connection to the organization's mission, services, results, or other factors.

9.a.(4) Donors want to know that their donations make an impact for the persons served and that donations made to a specific fund or toward a specific purpose are actually used for that purpose. Organizations demonstrate fiscal responsibility and transparency regarding their use of funds for identified purposes.

Examples

9.a.(1) Written procedures might address which individual, committee, or department has authority and responsibility for the organization's fundraising activities; how the individual, committee, or department responsible for oversight fits into the larger organizational structure; and requirements for reporting.

9.a.(2)(a) Written procedures might address the mechanism(s) for and frequency of donor solicitation, what groups or individuals (e.g., persons currently participating in a program) can or cannot be solicited), and any state/provincial or other type of registration required to conduct certain charitable solicitations.

9.a.(2)(b) Written procedures might address how the organization will communicate with donors (e.g., in person or by mail, email, telephone, or social media channels), at what frequency, and what information will be exchanged. Written procedures might also include how the organization will handle requests to discontinue or restart communication with a donor and how it will maintain the currency of its records used for communication; e.g., relocation or death of a donor.

9.a.(2)(c) Written procedures might address the recognition of donors by name, donation amounts or other descriptors, and matching donations.

9.a.(2)(d) Written procedures might address how the organization will maintain the confidentiality of donors in accordance with applicable laws and regulations, such as HIPAA or PIPEDA, and donor wishes; e.g., a donor who wants to remain anonymous.

9.a.(3) Written procedures might address how the fair market value of noncash donations such as clothing, electronics, furniture, and other goods or services is determined and who may make such determinations; and what to do if a donor requests a receipt for a higher value than the donation is worth.

9.a.(4) Written procedures might address how funds or other donations will be applied in accordance with donor intent, such as a capital campaign to fund a new building or renovations; a golf tournament, casino night, or auction to fund the purchase of a vehicle to transport persons served or new equipment that will be used by persons served; or ongoing efforts to raise funds to support services for persons who would otherwise be unable to participate in the organization's programs/services.

9.a.(5) Written procedures might address what documentation is required to comply with legal and regulatory requirements and/or to satisfy the organization's requirements; how long documentation is retained; how documentation regarding fundraising and donors is kept separate from other administrative recordkeeping; and
whether information such as credit card and bank account numbers is kept on file.

9.a.(6) Written procedures might address in what capacity volunteers may be involved in fundraising activities and what the expectations are of those roles, recruitment of volunteers, training and supervision of volunteers, dismissal of volunteers, and background checks if necessary.

9.b.(2) Ongoing training may be provided when there is a change in fundraising procedures or practices, a change in the scope of an organization’s fundraising efforts, or a change in the legal or regulatory requirements related to fundraising to which the organization is subject.

Resources
- Charity Watch: [www.charitywatch.org/home](http://www.charitywatch.org/home)
- Charities Review Council: [www.smartgivers.org](http://www.smartgivers.org)
- Charity Navigator: [www.charitynavigator.org](http://www.charitynavigator.org)
- CFRE International: [www.cfre.org](http://www.cfre.org)
- Association of Fundraising Professionals: [www.afpnet.org](http://www.afpnet.org)
- Charities Institute Ireland Guidelines for Charitable Organisations Fundraising from the Public: [www.charitiesinstituteireland.ie/guidelines](http://www.charitiesinstituteireland.ie/guidelines)

9.a.(3) Resources related to valuing of donations include:
- Goodwill: [www.amazinggoodwill.com/donating/IRS-guidelines](http://www.amazinggoodwill.com/donating/IRS-guidelines)


Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Organizational chart
- Policy on corporate compliance, if applicable
- Documented designation of staff member to serve as the organization’s corporate compliance officer
- Written ethical codes of conduct
- Mission and values statements
- A budget
- A strategic plan
- Program outcomes
- Current information on file pertaining to applicable legal and regulatory requirements
- Information related to advocacy activities
- Information related to obtaining input from the persons served
- Surveys, assessments, or reports of input gathered from the persons served, personnel, and other stakeholders
- Written procedures to deal with allegations of violations of ethical codes
- Written procedures related to organizational fundraising, if applicable
B. Governance

Description
The governing board should provide effective and ethical governance leadership on behalf of its owners'/stakeholders' interest to ensure that the organization focuses on its purpose and outcomes for persons served, resulting in the organization's long-term success and stability. The board is responsible for ensuring that the organization is managed effectively, efficiently, and ethically by the organization's executive leadership through defined governance accountability mechanisms. These mechanisms include, but are not limited to, an adopted governance framework defined by written governance policies and demonstrated practices; active and timely review of organizational performance and that of the executive leadership; and the demarcation of duties between the board and executive leadership to ensure that organizational strategies, plans, decisions, and actions are delegated to the resource that would best advance the interests and performance of the organization over the long term and manage the organization's inherent risks. The board has additional responsibilities under the domain of public trust, and as such, it understands its corporate responsibility to the organization's employees, providers, suppliers, and the communities it serves.

Applicable Standards
These standards apply only to the board vested with legal authority to direct the business and affairs of the organization's corporate entity. These standards may not be applied to bodies lacking governance authority granted by state or provincial corporation laws, such as advisory and community relations boards and management committees. These standards must be applied to all organizations seeking accreditation for a Continuing Care Retirement Community.
1.B. The board implements governance policies that:
   a. Facilitate ethical governance practices.
   b. Assure stakeholders that governance is:
      (1) Active in the organization.
      (2) Accountable in the organization.
   c. Meet the legal requirements of governance.

Intent Statements
The board should clearly document its approach and duties related to governance, including its compliance with applicable statutes and provisions of articles of incorporation and bylaws. Board members are subject to three basic legal duties in performing their responsibilities: duty of care, duty of loyalty, and duty of obedience. Accountability requires that oversight mechanisms be in place, such as meetings, reports, and timely reviews of corporate performance.

Examples
Examples could include:
- Documented governance policies.
- Annual review of bylaws (legal requirements).
- Delegation of authority to executive leadership with defined limits, such as financial limits.
- Assurance that internal control and risk management systems, delegated to executive leadership, are in place.
- Timely reviews of corporate performance (e.g., quarterly).
- Annual reports to stakeholders.
- Input meetings with stakeholders.
- How board members understand the organization's fundraising goals and strategies, identify prospective donors, and engage with donors.

1.B. Governance policies address:
   a. The selection of the board, including:
      (1) Board membership criteria.
      (2) Selection process.
      (3) Exit process.
   b. Board member orientation.
   c. Board development.
   d. Board education.
   e. Board leadership, including selection of:
      (1) Board chair.
      (2) Committee chairs.
   f. Board structure, including:
      (1) Board size.
      (2) Board composition.
      (3) Definition of independent, unrelated board representation.
      (4) Duration of board membership.
   g. Board performance, including:
      (1) Financial matters, if any, between the organization and individual board members, including:
         (a) Compensation.
         (b) Loans.
         (c) Expense reimbursement.
         (d) Stock ownership.
         (e) Other matters of financial interest.
      (2) Use of external resources, including, as applicable:
         (a) External auditors.
         (b) Executive compensation advisors.
         (c) Other advisors, as needed.
      (3) Self-assessment of the entire board at least annually.
      (4) Periodic self-assessment of individual members.
      (5) Written conflict-of-interest declaration that is signed at least annually.


(6) Written ethical-code-of-conduct declaration that is signed at least annually.

(7) External interactions.

**Intent Statements**

2.a. The board has sole responsibility to determine appropriate skills and characteristics required for a competent and contributing board member. Each organization and its board must consider and identify its own member criteria (such as skills, diversity, representation of person served) and follow a selection process that accounts for the perceived needs of the board at the time of selection, attracting board members who have the time to devote to board activities to advance the organization’s purpose. Establishing membership criteria and defining a selection process should attract board members with the necessary skills and knowledge to do their job well.

The board should also manage its own governance performance by reviewing the collective board and individual members. In the event that performance issues arise with any specific board member (such as not attending meetings or lack of meaningful participation) the board must clearly identify its protocol to discharge a board member in a defined exit process.

2.b. Board member orientation usually requires that both the board and executive leadership conduct a comprehensive orientation process to ensure that the board member becomes familiar with the organization’s vision, mission, strategic direction, values, ethics, financial matters, governance practice, and policies in keeping with legal and/or other reporting requirements (e.g., annual tax filings).

2.c.–d. The organization should continually make efforts to build governance capacity through ongoing education. Rather than specifically relying on the individual expertise of a particular board member, the organization should make a concerted effort to advance the skills of the entire board, as the whole board is ultimately accountable, speaking with one voice.

2.e. The board should act freely to select a chair who is best for the board and organization at a given time. With respect to selecting the board chair or specific committee chairs, the organization should identify those criteria and selection processes.

2.f.(1)–(4) Good governance means performing effectively in clearly defined roles and functions. The structure of governance—board size, mix, and terms—are all decisions unique and specific to each organization.

Each organization should assess the optimum number of board members it needs with the requisite skills to thoroughly exercise governance oversight. It is the board’s responsibility to decide how it should strike a balance between the broad-based skills and experiences necessary for the board, with the pragmatic consideration of managing the structure and process of a larger board. Although larger boards may bring diverse skills, they do not necessarily bring better governance.

The approach an organization takes regarding the term of board membership is also subject to board deliberation and decision. No term limits, with acceptable board performance, ensures continuity in knowledge and community relationships. Natural attrition and term limits bring renewal and new vigilance by virtue of new skills and experiences of new members. Boards that frequently turn over tend to create organizational instability as both knowledge and experience are lost to the organization. The board must determine its approach in the context of the organization.

Board member independence and unrelatedness to executive leadership allow the board to act without undue influence from management. Further, when selecting a qualified candidate for board membership, a mix of members who have no ties or relationships to the organization is one way of ensuring independence. This effort can be satisfied through at-large members who can balance the varied interests of board members. Independent and unrelated board members may sometimes lead the governance management or executive compensation committees to enhance accountability.

2.g.(1) The board must set the ethical tone in the organization and model integrity in its conduct. In the case of publicly traded or other for-profit organizations, the board may receive compensation and other forms of financial incentives. In not-for-profit organizations, there may be other...
Section 1.B. Governance

financial links not directly apparent. Board policy should address these issues, supported by signed conflict of interest and ethical code of conduct declarations.

2.g.(2) Many governance decisions are complex and significant; therefore, the board should seek expert advice. Although expert advice can be provided through the organization’s internal experts, the board should seek external professional advice on complex legal and financial issues as necessary. Access to external expert advice can be coordinated and supported by the organization’s executive leadership.

2.g.(3)–(4) The board as a whole should continuously assess its performance in an effort to determine its effectiveness in governing the organization. This assessment ensures that the board is fulfilling its duties and evolving within the context of challenges the organization may face. Assessing board achievement and opportunity to improve will facilitate an evolving governance model to ensure that its activities remain relevant and effective on behalf of owners/stakeholders. This concept also applies to individual board members.

2.g.(7) Outside parties may include advisors, regulators, investors, press, persons served, and other stakeholders.

Examples

2.e. A selection criterion for the finance/audit committee chair could ideally be a board member with a finance background.

2.g.(2) Examples of situations in which the use of external advisors or resources would be appropriate could include:

- Seeking financial or legal advice on a merger or acquisition.
- Getting advice from an expert on corporate risk management.
- Getting advice from a financial expert on organization investment policies.

2.g.(3) Whole board assessment strategies can include:

- Completing meeting questionnaires (e.g., questions rated strongly agree, agree, neutral, disagree, or strongly disagree).
  - We (the board) spent our time on the most important governance topics.
  - We used our time effectively.
  - The meeting was chaired effectively.

- Discussing the board’s effectiveness at the conclusion of each board meeting, rolled into a year-end review documented in board minutes.

- Completing a year-end questionnaire tallied for board discussion. The following are sample questions, which can be rated by board members as Excellent, Good, Fair, Poor, or N/A:
  - Legal Frameworks:
    - Statements in the governing documents (e.g., bylaws, policies) setting forth the board’s function and duties are:
  - Board Structure:
    - The board’s size in relation to the organization’s needs is:
    - The board’s spread and balance in regard to expertise, age, diversity, interest, and points of view are:
  - Board Comprehension:
    - The board’s comprehension of the interests of various constituencies (funders, persons served, and advocates) with which the organization deals is:
  - Board Practices:
    - The board’s orientation to the organization is:
    - The frequency of board meetings in relation to organizational needs is:
    - The board’s practices with regard to amendments of bylaws are:
    - The board’s practices with regard to election of officers are:
    - The board’s practices with regard to establishing committees and their mandates are:
board's performance in formulating the organization's long-term goals is:
- The board's ability to monitor its own accomplishments and progress is:
- Performance standards expected by the board for attending all regularly scheduled meetings are:
- Performance standards expected by the board for committee participation are:
- Performance standards expected by the board for referral of prospective board members are:

- Relations with Executive Leadership:
- The board's working relationship with the chief executive officer is:
- The definitions of the roles of the chief executive officer and board are:

2.g.(4) Individual board self-assessment can include:

- A yearly self-assessment questionnaire and resulting discussion with the board chair. The following are sample questions, which can be rated by board members as Excellent, Good, Fair, Poor, or N/A:
  - My understanding of the organization's mission, vision, and core values is:
  - My understanding of the legal requirements and stipulations under which the board acts is:
  - When outside auditors present the financial statements, my understanding of those documents is:
  - My attendance at board meetings is:
  - My preparedness for board and committee meetings is:
  - My working relationship with other board members is:

1.8. 3. The board's relationship with executive leadership includes:
   a. Delegation of:
      (1) Authority to executive leadership.
      (2) Responsibility to executive leadership.
   b. As appropriate, access to personnel.
   c. Support of governance by the organization.

Intent Statements
See the Glossary for the definition of executive leadership.

3.a. Determining the relationship between the board and the organization's executive leadership requires significant thoughtfulness and diligence to be clear about the functions of governance versus the duties delegated appropriately to the organization's management. Although each organization determines appropriate roles, generally boards ensure that the organization has a vision for its future via goals, aims, missions, or ends and that management work is conducted legally, ethically, and with integrity to achieve those goals. The board's accountability to its stakeholders is achieved by holding the organization's management accountable for performance. The board delegates authority to management to conduct business via resource use (e.g., money, people, technology) and ensures that executive leadership develops plans and acts to achieve organizational goals. This delegation and review process is a continuous oversight mechanism, culminating in a review at least annually of the organization's (and therefore, the executive leadership's) success.

This delegation of authority differentiates between the authority of the executive leadership and the authority of the board.

3.b. From time to time, the board may need access to varied management and staff in carrying out its governing duties. So as not to cross into management authority, the board should be clear on when and how it may consult with other management/staff to enhance its governance duties. This relationship is established between the board and executive leadership so that managerial operations are maintained as a
priority for those assigned to that responsibility. The organization should ensure that the board has appropriate administrative support.

Examples

3.c. The organization may show support of the governing body by how it shares information with members of the governing body; how time and space are provided in support of governance-related work; the types of resources made available to the board for educational purposes such as orientation to the organization, memberships in professional associations in the field, or membership in an organization such as Boardsource® (www.boardsource.org), which promotes effective governance practices.

1.B. 4. Board processes include:
   a. Agenda planning.
   b. Developing meeting materials.
   c. Distributing meeting materials.
   d. Overseeing the following committee work, as applicable:
      (1) Governance development.
      (2) Governance management.
      (3) Financial audit.
      (4) Executive compensation.
      (5) Other pertinent activities, as defined by the board.

1.B. 5. Governance policies address executive leadership development and evaluation, including:
   a. A formal written review of executive leadership performance:
      (1) At a frequency determined by the governance.
      (2) In relation to:
         (a) Overall corporate performance versus target.
         (b) Individual performance versus target, if applicable.
         (c) Professional development.
   (d) Professional accomplishments.
   (e) Professional opportunities.

   b. An executive leadership succession plan that is:
      (1) Reviewed at least annually for relevance.
      (2) Updated as needed.

Intent Statements

Evaluation of executive leadership is an essential part of performance management and should include opportunities for continued growth and development.

5.b. Succession planning for executive leadership ensures continuity of leadership due to the planned or unplanned departure of the chief executive. To manage associated risks of unplanned leadership vacancies, the board should have a plan for this. Details of such a plan vary by organization and often the current executive leadership is charged with providing this plan to the board annually.

Examples

5.b. The succession plan for review may include a letter from the executive leadership to the board identifying two internal candidates who can fill the position on a temporary or permanent basis. Often, this leads the board into a joint discussion with executive leadership on the skills, capacity, and depth of leadership potential in the organization.

A thorough competency-based succession program should assess competencies necessary for organizational leadership positions, match against a 360 review of potential internal candidates, and identify promotion or development opportunities.

1.B. 6. Governance policies address executive compensation, including:
   a. A written statement of total executive compensation philosophy.
   b. Review by an authorized board committee composed of independent, unrelated board members.
c. Defined total compensation mix, up to and including, as warranted:
   (1) Base pay.
   (2) Incentive plans.
   (3) Benefit plans.
   (4) Perquisites.

d. Total compensation references to:
   (1) Market comparator data.
   (2) Functionally comparable positions.

e. A documented process that outlines:
   (1) Terms of compensation arrangements.
   (2) Approval date.
   (3) Names of board members on the committee who approved the compensation decision.
   (4) Data used in the compensation decision.
   (5) Disclosures of conflict of interest, if any.
   (6) Review of executive compensation records at least annually.
   (7) Authority of board members to exercise executive compensation actions.

Intent Statements

The board’s role in determining executive compensation remains a high-profile task for the governing board whether organizations are for profit or not for profit. A board-endorsed compensation philosophy is intended to provide a broad-based foundation for designing an effective compensation and performance management plan for executive leadership. It should be broad enough to provide an enduring foundation, yet be specific enough for the board to make compensation decisions at least annually on an informed and reasonable basis. A compensation plan must attract and retain leadership talent, yet respond to market trends, reflecting the value of the functional demands of executive work and rewarding performance results. Further, tests of reasonableness regarding executive pay also place board members at potential personal risk. That risk is minimized by ensuring that executive compensation decisions are independently approved by the governing board or committee acting on behalf of the board in a non-conflict-of-interest position. Further, appropriate practice would also involve using comparability data before approving a compensation arrangement, followed by documenting the process that supports that decision.

Examples

As a general guide, publicly traded for-profit companies have models of executive compensation programs/approaches or protocols that detail the principles and philosophies of various compensation models. These, with modification, could be used by not-for-profit organizations.

Comparison to or benchmarking of total compensation plans can include many sources: salary surveys (regional/national), profit versus non-profit, functional responsibility of leadership regardless of tax status, and comparators or comparator mixes that can establish a policy line for executive leadership pay.

Resources

For U.S. nonprofits, Section 53.4958-6 of the Treasury Regulations also outlines a process that a board of a tax-exempt entity should follow to reduce exposure to penalties in relation to unreasonable compensation.

правляется канадская федерация союзов профсоюзов может быть полезным ресурсом для информации о компенсации.

1.B. 7. The governing board reviews its governance policies at least annually.

Examples

Examples of how to conduct this review may include a review of policies by a board committee with the review documented in meeting minutes, or a staff liaison to the board may help to facilitate this review with the board.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Board organizational chart
- Ethical practices policy
- Board selection and composition policies
- Board leadership policies
- Board structure and performance policies
- Documentation of board self-assessment at least annually
- Individual board member self-assessment documentation
- Conflict-of-interest declarations signed at least annually
- Ethical code of conduct declarations signed at least annually
- Sample board meeting agendas/meeting minutes
- Sample meeting materials
- Executive leadership development and evaluation policies
- Executive compensation policies
- Executive leadership succession plan, reviewed at least annually
- Formal written review of executive leadership performance
- Evidence of review of governance policies at least annually
Set Strategy

C. Strategic Planning

Description

CARF-accredited organizations establish a foundation for success through strategic planning focused on taking advantage of strengths and opportunities and addressing weaknesses and threats.

1. The ongoing strategic planning of the organization considers:
   a. Expectations of persons served.
   b. Expectations of other stakeholders.
   c. The competitive environment.
   d. Financial opportunities.
   e. Financial threats.
   f. The organization’s capabilities.
   g. Social determinants of health.
   h. Demographics of the service area.
   i. The organization’s relationships with external stakeholders.
   j. The regulatory environment.
   k. The legislative environment.
   l. The use of technology to support:
      (1) Efficient operations.
      (2) Effective service delivery.
      (3) Performance improvement.
   m. Information from the analysis of performance.

Intent Statements

1.g. The World Health Organization describes social determinants of health as the conditions in which people are born, grow, live, work, and age. According to Healthy People, these conditions can affect a wide range of health, functioning, and quality-of-life outcomes and risks. Through consideration of the demographics of the service area, an organization may identify social determinants of health that can impact results for the persons served and the durability of outcomes they achieve. Strategic planning may include efforts to improve those conditions and reduce barriers for the persons served.

1.j.(1)–(3) Technology has an ever-increasing role and presence in today’s human services environment. Although the use of technology and the sophistication of that technology will vary among organizations, each organization considers current literature and professional consensus in determining its current and future technology needs and identifies the resources needed to advance its use of technology to support operations, effective service delivery, and performance improvement.

This standard relates to Standards 1.J.1. and 1.J.2. See the Glossary for the definition of strategic planning.

Examples

1.f. Capabilities may include areas such as human resources, research and development, integration with or development of new segments of the continuum, and technology.

1.g. Examples of social determinants of health include, but are not limited to:
   ■ Availability of transportation options.
   ■ Availability of affordable, accessible, safe housing and utilities.
   ■ Availability of nutritious food, clean water, and toxin-free environments.
   ■ Socioeconomic conditions such as poverty.
   ■ Access to healthcare services.
   ■ Access to social support.
   ■ Exposure to trauma, violence, or crime.
   ■ Social support and community inclusivity.
   ■ Recreation and leisure activities.
Section 1.C. Strategic Planning

- Availability of community-based resources in support of community living.
- Access to educational, economic, and job opportunities.

1.h. An organization is 30 years old and was once in a very rural area. The demographics of the area have dramatically changed as the area has become more industrial. This information affects many areas including expectations, financials, and demographics.

1.i. External stakeholders may include educational institutions.

1.k. An organization evaluates changes in public funding from legislation, such as the Patient Protection and Affordable Care Act and Medicaid waivers, and integrates the information into the planning process.

1.l.(1)–(2) As part of strategic planning, the organization explores technology that would allow point-of-service entries into the electronic medical record by nurses, physicians, and therapists and immediate access to diagnostic test results. A multi-step hardware and software acquisition and implementation plan is proposed for integration into the organization's strategic plan.

1.C. 2. The organization implements a strategic plan that:

a. Is developed with input from:
   (1) Persons served.
   (2) Personnel.
   (3) Other stakeholders.

b. Reflects the organization's financial position:
   (1) At the time the plan is written.
   (2) At projected point(s) in the future.
   (3) With respect to allocating resources necessary to support accomplishment of the plan in the following areas:
      (a) Financial.
      (b) Workforce.

c. Sets:
   (1) Goals.
   (2) Priorities.

d. Is reviewed at least annually for relevance.

e. Is updated as needed.

Intent Statements

The strategic plan sets forth an organizational roadmap for the future in consideration of relevant business, environmental, and other factors. Because sound business practice demands that the plan be used as a dynamic tool, it should be reviewed at least annually and modified as appropriate.

Examples

The strategic plan addresses the programs/services seeking accreditation. If the programs/services are part of a larger organization and not specifically addressed in its strategic plan, the programs/services may establish a separate plan or generate a supplement to the organization's plan that addresses input, financial position, and goals and priorities pertinent to the programs/services.

2.a. Input from persons served, personnel, and other stakeholders considered in developing the strategic plan might include information from input forums, surveys, and performance improvement activities.

2.b.(2) An organization is better able to define success with proactive long-term financial planning measures. As the future financial position of an organization is impacted by ever-changing marketplace factors, such as coding, payment, reimbursement, and costs, the strategic plan might include information reflecting long-term financial planning to support the goals and priorities identified. Points in the future might be one year, two years, or other points in time depending on regulatory and business factors impacting the organization.

2.d.–e. An organization determines the method of review and update. Significant changes in factors impacting the strategic plan could prompt leadership to consider reviewing or updating more often than annually to maintain a dynamic and relevant plan.
Section 1.C. Strategic Planning

1.C. 3. The strategic plan is shared, as relevant to the needs of the specific group, with:
   a. Persons served.
   b. Personnel.
   c. Other stakeholders.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Strategic plan
- Strategic planning documents
- Leadership or management meeting minutes, where strategic planning was discussed
- Financial reports
- Input received from persons served, personnel, and other stakeholders
- Meeting agendas or minutes where strategic plan has been shared with personnel
Persons Served and Other Stakeholders—Obtain Input

D. Input from Persons Served and Other Stakeholders

Description
CARF-accredited organizations continually focus on the expectations of the persons served and other stakeholders. The standards in this subsection direct the organization’s focus to soliciting, collecting, analyzing, and using input from all stakeholders to create services that meet or exceed the expectations of the persons served, the community, and other stakeholders.

1.D. 1. The organization demonstrates that it obtains input:
   a. On an ongoing basis.
   b. From:
      (1) Persons served.
      (2) Personnel.
      (3) Other stakeholders.
   c. Using a variety of mechanisms.

Intent Statements
Input is requested and collected to help determine the expectations and preferences of the organization’s stakeholders and to better understand how the organization is performing from the perspective of its stakeholders. The input obtained relates to the persons served and the organization’s service delivery and business practices. The organization identifies the relevant stakeholders, in addition to the persons served and personnel, from whom it solicits input.

Examples
There are a variety of mechanisms to solicit and collect information. They range from the informal to the formal. Some examples include:
- Input forums such as advisory groups and forums of persons served.
- Written or telephone surveys.
- Suggestion boxes.
- Complaint or incident summaries.
- Performance improvement activities.
- Councils or committees composed of persons served.
- Strategic planning, including:
  - Finance.
  - Human resources.
  - Environmental scans.
- Program/service development.

Please see the Glossary for the definition of strategic planning.

Resources

1.D. 2. The leadership:
   a. Analyzes the input obtained.
   b. Uses the input in:
      (1) Program planning.
      (2) Performance improvement.
      (3) Strategic planning.
      (4) Organizational advocacy.
      (5) Financial planning.
      (6) Resource planning.
      (7) Workforce planning.
**Intent Statements**

The input is continually analyzed, and the analysis is integrated into the business practices of the organization. The input is analyzed to help determine if the organization is:

- Meeting the current needs of the persons served and other stakeholders.
- Offering services/products that are relevant to the persons served and other stakeholders.
- Identifying potential new opportunities for the growth and development of programs and services.

**Examples**

During the survey, the organization should be prepared to share how it has used its analysis of information for program planning, performance improvement, strategic planning, organizational advocacy, financial planning, resource planning, and workforce planning.

Examples might be the opening of a new wellness program after collecting information from persons served and key referral sources in the community, a plan to expand the parking lot for a community-based program because of complaints of no parking spaces, the addition of new lighting in common areas due to low satisfaction of persons served with their ability to see while engaged in social activities, or the addition of new volunteer opportunities due to the increased presentations to business groups about the advantages of successful volunteer work with the aging services continuum.

Input can be used in various ways: developing or revising individual service plans; changing service delivery designs; developing, improving, or eliminating services; developing short- and long-range planning; and identifying personnel training needs.

2.b.(4) Organizational advocacy may be defined as intentional, possibly ongoing value-added activities of workplace members made to enhance the achievement and well-being of the members of the organization. These activities are also referred to as social accountability. Examples include having the organization engaged in legislative advocacy for research on certain conditions impacting persons served or employment-related issues that may impact the workforce of the organization. It might be related to neighborhood safety or zoning-related topics.

**Documentation Examples**

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Leadership and other meeting minutes, including persons served meetings
- Written surveys and results
- Strategic planning documents
- Satisfaction surveys from persons served and other stakeholders, such as board members, funder and referral sources, parents and guardians, staff persons, and other community members
- Information regarding community input and input from persons served
Implement the Plan

E. Legal Requirements

Description
CARF-accredited organizations comply with all legal and regulatory requirements.

1.E. The organization demonstrates a process to comply with the following obligations:
   a. Legal.
   b. Regulatory.
   c. Confidentiality.
   d. Reporting.
   e. Licensing.
   f. Contractual.
   g. Debt covenants.
   h. Corporate status.
   i. Rights of the persons served.
   j. Privacy of the persons served.
   k. Employment practices.
   l. Mandatory employee testing.

Intent Statements
The organization should engage in activities designed to promote awareness, understanding, and satisfaction of its various obligations at all times. Satisfaction of obligations is necessary for the organization's success, sustained existence, and ability to positively affect the lives of persons served. Failure to satisfy obligations may result in monetary or other penalties, potentially impacting the viability of the organization and harm to those the obligations are intended to protect. The organization should monitor its environments for new and revised obligations and utilize knowledgeable resources to become familiar with obligations and the requirements to meet them.

Examples
Human resources and/or a lead operations staff person can identify the applicable legal and regulatory requirements that are important in various staff responsibilities and may ensure that the job descriptions reflect this. Alerts or other communications could be provided to personnel and others regarding legal/regulatory topics to be aware of. The systems, such as meetings or other methods to help personnel stay current on new topics, are identified. Regulatory content may be included in trainings to ensure accurate knowledge and compliance. This process might also include retaining a legal advisor.

1.a.–e. With regard to fundraising practices, compliance with legal, regulatory, confidentiality, reporting, and licensing requirements may include valuing donations according to guidelines, annual tax filings, documentation provided to donors, and obtaining the required licenses to conduct fundraising activities and events.

1.d. Reporting requirements may include financial solvency.

1.E. The organization implements written procedures to guide personnel in responding to:
   a. Subpoenas.
   b. Search warrants.
   c. Investigations.
   d. Other legal action.

1.E. Policies and written procedures are implemented that address:
   a. Confidential administrative records.
   b. The records of the persons served.
   c. Security of all records.
   d. Confidentiality of records.
   e. Compliance with applicable laws concerning records.
   f. Timeframes for documentation in the records of the persons served.
Intent Statements

In order to protect the privacy of all stakeholders and any confidential information that its records may contain, an organization ensures that it addresses the applicable legal and regulatory requirements concerning privacy of health information and confidential records. Security includes such things as storage, protection, retention, and destruction of records. Safeguards such as reasonable protection against fire, water damage, and other hazards do not need to be described in writing.

This standard applies to current and historical records and to hard copy records as well as electronic records.

Organizations are encouraged to review current provisions of legislation on freedom of information and protection of privacy (such as HIPAA and Health Information Technology for Economic and Clinical Health [HITECH] in the U.S. and Personal Information Protection and Electronic Documents Act [PIPEDA] in Canada), for potential impact on the maintenance and transmission of protected health information. Of particular note are provisions related to information security, privacy, and electronic data interchange.

Examples

Security and confidentiality can be addressed through mechanisms such as having designated personnel who are responsible for records maintenance and control, limiting access to confidential records to authorized personnel only, protecting records from permanent loss or damage, ensuring that electronic records have regular backup, and clearly defining and implementing timeframes and procedures for retention and destruction of records.

3.a. Confidential administrative records could include personnel records, contracts, budgets, billing information, legal information, records of donations and/or donors, and other protected or sensitive information and records.

3.b. Records are not required to be kept in a single location. However, if they are kept in several locations, they may be controlled from a central location by a designated staff member, with the location of each file readily identified. If records are stored in locations other than the central location, the safeguards for each of these locations may be similar to the safeguards for the central location.

Safeguards such as reasonable protection against fire, water damage, and other hazards do not need to be described in writing.

3.f. An organization would establish its own timeframes for entries into records which could include timeframes for entering critical incidents or interactions into the records of the persons served and timeframes for entering confidential data into administrative records. It would also be the responsibility of an organization to determine what the content of its records will include or exclude.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Reports from regulatory agencies
- Reports associated with legal actions
- Reports associated with contractual relationships
- Policies and written procedures regarding administrative records and records of the persons served
- Personnel policies
- Written procedures for responding to various legal actions
- For organizations in the U.S., I-9 information, if applicable
F. Financial Planning and Management

Description
CARF-accredited organizations strive to be financially responsible and solvent, conducting fiscal management in a manner that supports their mission, values, and performance objectives. Fiscal practices adhere to established accounting principles and business practices. Fiscal management covers daily operational cost management and incorporates plans for long-term solvency.

1.F. The organization’s financial planning and management activities are designed to meet:

   a. Established outcomes for the persons served.
   b. Organizational performance objectives.

Examples
Strategic planning and financial planning are integrated to ensure that initiatives or changes in programs are adequately funded or supported to maximize success.

1.a. This may tie to Section 1.M. Performance Measurement and Management standards on identifying and measuring service delivery performance indicators such as results achieved for the persons served, experience of services and other feedback, efficiency, and service access.

1.b. The organization’s performance objectives may include, but are not limited to areas of potential financial risk such as reductions in funding or new regulations that might impact services or expand the population to be served. This may tie to Standard 1.M.9. related to setting and measuring performance indicators for business function improvement.

2. Budgets are prepared:
   a. Prior to the start of the fiscal year.
   b. That:
      (1) Include:
         (a) Reasonable projections of:
             (i) Revenues.
             (ii) Expenses.
             (iii) Capital expenditures.
         (b) Input from various stakeholders, as required.
         (c) Comparison to historical performance.
         (d) Consideration of necessary cash flow.
         (e) Consideration of external environment information.
      (2) Are disseminated, as appropriate, to:
         (a) Personnel.
         (b) Other stakeholders.
      (3) Are:
         (a) Written.
         (b) Approved by the identified authority.

Examples
The annual budget can reflect projected income and expenses. Input from professional and administrative personnel in budget development may demonstrate the organization’s intent to anticipate its fiscal needs.

Input from persons served can be gathered by a variety of means. For example:

- Formal meetings to discuss the budget.
- Informally, via ongoing conversations with staff.
- Through participation on the board or advisory groups.

2.b.(3)(b) Approval of the budget could be conducted by an owner, executive leadership, governing board, or other authority. If an organization is dependent on funding from an external entity’s budget that has not been finalized prior to the beginning of the fiscal year, an organization
may adopt a provisional budget until the final budget is approved for the year.

1.F. Actual financial results are:
   a. Compared to budget.
   b. Reported, as appropriate, to:
      (1) Personnel.
      (2) Persons served.
      (3) Other stakeholders.
   c. Reviewed at least monthly.

Examples

3.b.(2) Persons served may be interested in the financial status, stability, or viability of an organization for a variety of reasons; e.g., they are personally responsible for the payment of fees; they anticipate being engaged with the organization for an extended period of time; they are seeking new or enhanced equipment, technology, facilities, or programs/services and want to know whether the organization's budget will support these; they are considering donating to or investing in the organization; etc.

Nonprofit organizations are subject to reporting requirements, including financial reporting, with information publicly available. In some settings, a contract for services between an organization and a person served may include requirements for reporting specified information. An organization may publish annual reports, performance reports, newsletters, or news releases, or it may post information on a website that reflects its overall status and plans, including the finances needed to support them.

3.c. The review of actual financial results may be conducted by program management, finance staff, or the governing board.

1.F. The organization identifies and reviews, at a minimum:
   a. Revenues.
   b. Expenses.
   c. Internal:
      (1) Financial trends.
      (2) Financial challenges.
      (3) Financial opportunities.
      (4) Management information.

d. External:
   (1) Financial trends.
   (2) Financial challenges.
   (3) Financial opportunities.
   (4) Industry trends.

e. Financial solvency, with the development of remediation plans if appropriate.

Examples

External events that have a financial impact on the organization can include items such as:
- Changes in reimbursement rates.
- Competition in the marketplace.
- Changes in preferences of persons served.
- Interest rates and the availability of financing.
- Regulatory and legislative changes.

Management information can include items such as:
- Amount of time it takes to sell or lease a vacant unit.
- Percentage of private pay versus Medicare/Medicaid or pay from other public funds.

An organization might benefit from knowing how sensitive it is to a variety of issues and how much of a drop in certain areas of revenue can occur before it begins to lose cash, possibly leading to a default on debt repayment. For example, how low can persons served census from a certain payer source become before the decline causes the organization stress in cash flow or with meeting the terms of debt.

An organization might develop a remediation plan to determine underlying causes of the decline in number of persons served through a variety of means, which might include reassessing the performance of the liaisons to referring hospitals, community-based providers, and referring physicians; conducting a survey of past persons served; or conducting a competitive analysis to determine if the census decline is widespread or only at one organization.

A remediation plan could identify strategies to increase the number of persons served through strategies such as advertising and/or senior management meetings with referring hospitals,
physicians, or other referral sources to ensure that they are informed about the services offered by the organization.

An organization can demonstrate that consideration of these items occurs through meeting minutes or other type of document.

4.c. Key metrics can include census and utilization.

4.e. Financial solvency could be described as the ability of an organization to meet its financial obligations, to meet long-term expenses, and to accomplish long-term expansion and growth.

5. An analysis of financial results:
   a. Is conducted at least annually.
   b. Is documented, including:
      (1) Trends.
      (2) Areas needing improvement.
      (3) Actions to address the improvements needed.
      (4) Implementation of the actions.
      (5) Whether the actions taken accomplished the intended results.

6. If the organization has related entities, it identifies:
   a. The types of relationships.
   b. Financial reliance on related entities.
   c. Responsibilities between related entities and the organization, including:
      (1) Legal.
      (2) Contractual.
      (3) Other.
   d. Any material transactions.

Examples
Organizations often form strategic relationships with other entities to share financial and non-financial resources or to guarantee debt. At times, organizations benefit from a third-party revenue source. The relationship of this revenue source and the risks or value of this relationship should be disclosed.

Examples of relationships include:
- Parent-subsidiary structures.
- Affiliations.
- Alliances.
- Guarantees.
- Limited partnerships.
- Other third-party operating support.
- Material contracts such as food services, pharmacy, and therapy.
- Financial support from related foundations.

Disclosure of these relationships can be accomplished through:
- Audited financial statements.
- Annual reports distributed to residents and persons served.
- Marketing materials.
- Tax report filings.

6.d. Material, when used in accounting, is defined as the magnitude of an omission or misstatement of accounting information that makes it probable that the judgment of a reasonable person relying on that information would have been changed or influenced by the omission or misstatement. When used in finance, it refers to the magnitude of the financial impact on an organization. If the magnitude of the items relative to the whole organization is significant, then it is material. For example, a company with $2,000 of total assets has $1,000 worth of investments, the investment is material. A $1,000 impact on a $500 million total asset corporation is immaterial.
1.F. 7. The organization:
   a. Implements fiscal policies and written procedures, including internal control practices.
   b. Provides training related to fiscal policies and written procedures to appropriate personnel, including:
      (1) Initial training.
      (2) Ongoing training.

Intent Statements
To reduce risk, it is important that the organization, regardless of size, establish who has responsibility and authority in all financial activities, such as in purchasing materials and capital equipment, writing checks, making investments, fundraising, and billing.

Examples
7.a. Policies and written procedures may address methods for receiving cash, checks, donations, or other financial instruments; disbursing funds, including petty cash, other cash, checks, or other financial instruments; managing the use, receipt, or disbursement of funds through purchase orders, invoices, organizational credit cards and debit cards, and/or lines of credit with outside vendors; managing donations; and investing funds.

Written internal controls provide management with some assurance that information provided by the accounting system is reliable and timely; therefore, an auditor's report on internal control is not a substitute for an organization having internal control procedures.

1.F. 8. If the organization bills for services provided, it conducts a documented review of a representative sample of bills of the persons served:
   a. At least quarterly.
   b. That addresses:
      (1) Whether bills are accurate.
      (2) Trends.
      (3) Areas needing improvement.
      (4) Actions to be taken.

Intent Statements
A review of bills of the persons served to determine that they are accurate is a proactive method for an organization to help reduce or eliminate costly audit exceptions. This review and corresponding action will assist in that process.

Examples
8.b.(3)–(4) Actions to be taken address the areas identified as needing improvement. For example, errors in billing may be addressed with education for billing personnel on why bills were rejected or declined, training on proper coding, issuing corrected bills, or return of overpayments to persons served or payers. Service delivery personnel may be trained on requirements for documentation in the records of persons served that justifies the billing.

1.F. 9. The organization, if responsible for fee structures:
   a. Identifies the basis of the fee structures.
   b. Demonstrates:
      (1) Review of fee schedules.
      (2) Comparison of fee schedules.
      (3) Modifications when necessary.
   c. Discloses to the persons served all fees for which they will be responsible.

Intent Statements
An accountable organization assists the persons served in understanding the fee structure and whether there might be any additional charges to the individual.

Examples
On a regular basis, the organization can evaluate its current fee structure to ensure that the fees are adjusted as necessary to reflect changes in services, the cost of delivering services, third-party/funder rate adjustments, and the local market.

CCRCs can use a variety of techniques to determine fees, including actuarial studies and financial analyses. For example, CCRCs may use...
actuarial studies with mortality and morbidity tables to assess the likely inflow, outflow, and turnover of CCRC residents. Other CCRCs might use some combination of resident statistics, government reimbursement rates, marketing data, and operating costs. Although CARF does not require CCRCs to use actuarial studies, they may be required as part of financial feasibility studies necessary in the CCRC licensing process. Actuarial studies can be a useful tool for CCRCs that offer contracts which incur long-term liabilities such as guaranteeing healthcare services over the long term.

9.b. The organization may demonstrate this in different ways. It might include dates on documents, mention this activity in meeting minutes, various staff could discuss how this process occurred, etc.

9.b.(2) Comparison of fee schedules could be with what it has charged before and what new analysis might show is needed; it could be comparing to fee schedules from the funding source or other organizations. It does not require that it be external to the organization.

9.c. These may be called unfunded services, or services that include the beauty shop, meals, tuck shop, country store, café, carports, or covered parking spaces. Although disclosure in writing is not required, it may be useful to provide written disclosure to persons served.

Intent Statements

An accountant authorized by the appropriate authority means a CPA in the U.S.; in countries outside the U.S., the terminology for a similar accountant qualified to conduct a review or audit would be used. The CPA, chartered accountant, or similar accountant retained must be independent of the organization; i.e., may not be contracted with the organization for its regular accounting needs, represent the organization's funding sources, or be a member of the governance authority.

It is important for the organization to determine that its financial position is accurately represented in its financial statements. Accountants may typically undertake three types of engagements: audit, review, and compilation. Each is described in more detail below, but in summary, the audit is the most extensive effort and accordingly the highest cost to the organization.

An audit requires an examination of the financial statements in accordance with generally accepted auditing standards, including tests of the accounting records and other auditing procedures as necessary. An audit will result in a report expressing an opinion as to conformance of the financial statements to generally accepted accounting principles.

A review consists principally of inquiries of company personnel and analytical procedures applied to financial data. It is substantially less in scope than an examination using generally accepted auditing standards. Typically, a review will result in a report expressing limited assurance that there are not material modifications that should be made to the statements.

As part of a compilation engagement, an accountant will compile the financial statements based on management representations without expressing any assurance on the statements. A compilation will not meet this standard.

Examples

The scope of this independent examination may vary based on the accounting requirements to which the organization is subject. It may be a full audit or a review. For a governmental entity, this standard may be met by review within its own system of oversight.
10.a. An organization that is part of a larger entity may be included in the audit or review of the larger entity. In addition to documentation of the audit or review, the organization is expected to provide evidence that it was included in the process of the larger entity. This may be demonstrated through financial reports, subsidiary agreements, annual reports, or other business-related documents that provide evidence of the relationship of the organization to the larger entity.

11. If the organization takes responsibility for the funds of persons served, it implements written procedures that address:
   a. Identification of the role of the organization.
   b. How the persons served will give informed consent for the expenditure of funds.
   c. How the persons served will access the records of their funds.
   d. How funds will be segregated for accounting purposes.
   e. Safeguards in place to ensure that funds are used for the designated and appropriate purposes.
   f. When interest-bearing accounts are used, how interest will be credited to the accounts of the persons served.
   g. How account reconciliation is provided to the persons served at least monthly.
   h. How funds will be returned to the persons served upon transition/exit from the program.

Examples
The organization may function in an official capacity such as a representative payee or other formally appointed representative with financial responsibility for the person served, or it may safeguard funds as a courtesy to the persons served; e.g., holding money in a bank account or keeping money or credit cards in a secure place for use by or on behalf of the persons served. These may be referred to as Trust Accounts.

12. The organization’s independent financial audit is completed within 120 days of fiscal year end.

Examples
An organization may demonstrate conformance by sharing the cover letter that is received from the auditing firm.

Long-Term Financial Planning
CCRCs are complex organizations that often rely on a variety of revenue sources. Some CCRCs offer a resident contract that includes prepaid healthcare. Prudent financial management requires these organizations to have financial analysis and planning skills in order to monitor their financial operations, liquidity, and the capital structure of the organization, and to translate their analysis into financial plans that will ensure the long-term solvency of the organization.

13. The organization addresses:
   a. Margin/profitability, including:
      (1) Revenue and expenses related to the persons served.
      (2) Earnings related to businesses not directly related to the persons served (ancillary revenue) and third-party sources of revenue.
      (3) Expense management.
   b. Liquidity.
   c. Capital structure to ensure:
      (1) Financial flexibility.
      (2) Ability to meet the needs of persons served and other stakeholders.

Intent Statements
If the organization serves as a representative payee for the persons served, is involved in managing the funds of the persons served, receives benefits on behalf of the persons served, or temporarily safeguards funds for the persons served, it demonstrates that it has a system in place to protect the fiscal interests of the persons served.
d. Use of financial ratio information.
e. Bond covenant compliance, if the organization has bond covenants that must be met.

Intent Statements

Financially savvy organizations analyze the various revenue and expense components of the net income in order to make informed decisions. They understand the revenues/expenses associated solely with the delivery of services to residents and other persons served. They identify their financial reliance on nonresident income, such as contributions, investment earnings, and ancillary revenue (earned from services not related to delivery of services to residents, such as space rental and catering services). They must also understand their dependence on third-party funding sources necessary for them to meet their obligations to residents.

For CCRC programs, conformance to these standards is determined by the organization’s financial ratios calculated from the audit report for the most recent fiscal year. These financial ratios are then benchmarked against the average of three years of financial ratios data for the purpose of determining a level of conformance:

- 13.a.(1) Net operating margin ratio
- 13.a.(2) Total excess margin ratio
- 13.a.(3) Operating ratio
- 13.b. Days cash on hand ratio
- 13.c.(1) Cash to debt ratio
- 13.c.(2) Debt service coverage ratio

Effective asset/liability (balance sheet) management is a key to an organization’s long-term survival. It ensures that funds are available to meet strategic objectives; to replace, renovate, or expand current facilities; and to meet the contractual obligations of residents and persons served.

Examples

NOTE: Organizations submit audited financial statements and Ratio Pro for their most current fiscal year end with the survey application. If the organization has more current audited financial statements available once the survey has been scheduled, the most current audited financial statements and updated Ratio Pro should be submitted for use in assessing conformance to accreditation standards during the survey. CARF must receive the more current audited financial statements and updated Ratio Pro at least two weeks prior to the start of the on-site survey in order to be considered for inclusion.

NOTE: If CARF does not receive more current audited financial statements two weeks prior to the survey, the financial statements submitted with the Application will be used to determine conformance to the standards during the survey.

Refer to the annual publication Financial Ratios & Trend Analysis of CARF-Accredited Continuing Care Retirement Communities, Chapter 2. Margin (Profitability) Ratios for assistance in analyzing your organization’s margin (profitability). Ratio Pro has five margin/profitability ratios that will assist in your analysis:

- Operating Margin Ratio
- Operating Ratio
- Total Excess Margin Ratio
- Net Operating Margin Ratio
- Net Operating Margin—Adjusted Ratio

If an organization’s cash operating expenses exceed cash revenue, either unintentionally or by design, this shortfall will need to be funded. Examples of non-operating funding sources include:

- Admission fees of new residents.
- A parent or affiliate organization.
- Owners, including limited partners.
- Contributions.
- Unrestricted cash balances.
- Release of temporarily restricted net assets.
- Sale of investments.

Financial flexibility can be obtained by a variety of mechanisms, including:

- Legally structuring an organization to provide flexibility for debt cross-collateralization.
- Targeting a mix of fixed versus floating rate debt.
- Hedging variable rate debt with swaps, caps, and other derivative products.
- Hedging fixed rate debt with swaps.
Using obligated groups.

Using bond ratings and insurance.

Refer to the annual publication *Financial Ratios & Trend Analysis of CARF-Accredited Continuing Care Retirement Communities*, Chapter 3. Liquidity—Days Cash on Hand and Appendix A.

Discussion of Unrestricted Cash & Investments for assistance in analyzing your organization's unrestricted cash reserves. Ratio Pro has one ratio, Days Cash on Hand, to assist you in your analysis.

Unrestricted cash and investment balances are those asset balances that are freely available for use in operations. Therefore, temporarily or permanently restricted funds and those held in trust by a third party are not considered unrestricted cash/investments.

Unrestricted cash and investments include:

- Cash and short-term investments that are not subject to temporary or permanent restrictions.
- State operating reserves (if not required to be maintained in a separate escrow account).
- Board-restricted reserves.

**NOTE:** All trustee-held funds (debt service reserve, operating reserves) are not considered unrestricted.

The amount of days cash on hand will vary among organizations and is dependent on many factors, such as ownership type (for profit/non-profit), resident contract type (A, B, C, rental), and the philosophy of boards and senior management. For example, although both nonprofits and for-profit CCRCs take in cash entrance fees, the nonprofit is restricted by tax laws as to the amount of cash that can be legally removed from the organization. Conversely, for-profits are not limited on cash removal and may choose to withdraw the cash and maintain an alternative source of cash to fund operating shortfalls. Hence a for-profit may have lower days cash on hand.

Contract types will also influence the amount of days cash on hand. Contract type A organizations take in a larger upfront entrance fee and may invest these monies until they are needed for future healthcare costs. On the other hand, rental communities do not charge entrance fees and hence tend not to have large days cash on hand as they price their monthly service fees to cover their monthly expenses. Hence contract type A CCRCs will have a higher days cash on hand benchmark.

The *Financial Ratios & Trend Analysis of CARF-Accredited Continuing Care Retirement Communities* publication lists financial ratio benchmarks for CCRC contracts type A, B, and C.

Regardless of contract type, ownership type, etc., it is essential that organizations have access to liquidity either through days cash on hand or via a third party.

Third-party sources of liquidity may include:

- A parent or affiliate organization's legal guarantee to fund operating shortfalls.
- A parent or affiliate organization's history of funding operating shortfalls without a guarantee ("moral obligation").
- Foundations.
- Annual subsidies.
- Annual appropriation from Congress.
- Owner/limited partners.

Refer to the *Financial Ratios & Trend Analysis of CARF-Accredited Continuing Care Retirement Communities*, Chapter 4. Capital Structure Ratios for a discussion of how to measure and interpret balance sheet ratios. Ratio Pro has the following capital structure ratios to assist you in your analysis:

- Debt service coverage
- Debt service coverage—adjusted
- Cash to debt
- Debt to equity
- Debt to equity—adjusted
- Debt to total assets
- Average age of facility
- Capital expenditures as a percentage of depreciation

13.d. The organization may describe ways that it has used current financial ratio information to make planning decisions, or it may explain how using financial ratio data to benchmark itself to other organizations might inform changes to
operations or service delivery, or perhaps affirm current practices.

13.e. Examples shared with surveyors regarding how bond covenants are met might include periodic reports to bondholders, audit compliance reports, or other methods.

1.F. 14. If the organization has material investments, it implements an investment policy that:
   a. Addresses, at a minimum:
      (1) Portfolio return.
      (2) Portfolio risk.
      (3) Restricted cash reserves.
      (4) Investment instruments.
   b. Is reviewed at least annually for relevance.
   c. Is updated as needed.

Intent Statements

Organizations, especially those that offer life care contracts, generally have material assets to invest. Organizations with investment assets that are material to the organization must have policies and procedures in place to address investment portfolio return and risk.

Financially sound organizations maintain adequate unrestricted cash and investment reserves, or have access to third-party cash/reserves, to fund any unforeseen operating cash shortfalls and to meet the commitments of their residents and other persons served.

If an organization is required to maintain restricted reserves, it must have procedures to ensure that account balances are adequate and that time and usage restrictions are adhered to.

Examples

A sound investment policy should incorporate a variety of themes. For example:

- Investment objective: a statement outlining the purpose of the portfolio.
- Approved investments: the risk tolerance of an organization will dictate the percentage of investment assets in less risky, more liquid investments (cash, bank CDs, money market fund) and the percentage in riskier stocks and bonds.
- Investment restrictions: outlines the type of investments that have been prohibited; e.g., investments are restricted to bonds with a BBB rating or better.
- Investment safekeeping: what entity will hold the investment certificates and other documentation.
- Portfolio management:
   - How is portfolio performance monitored?
   - How often are results reviewed?
   - Whose responsibility is it to monitor the portfolio?

14.a.(3) This standard applies if the organization is required to maintain restricted reserves under debt agreements, state statutory requirements, and/or restricted endowments.

14.b. Review of the investment policy may be conducted by a finance committee, a management team, a financial expert that is retained by the organization for this review, or by another entity that the organization identifies as having the appropriate knowledge. The review could result in revision of the policy or it may result in affirmation that the policy is still relevant.

1.F. 15. Identified leadership of the organization reviews investment results at least annually in accordance with the investment policy.

1.F. 16. The organization implements a cash management strategy that:
   a. Addresses, at a minimum:
      (1) Accounts receivable management.
      (2) Accounts payable management.
   b. Is reviewed at least annually for relevance.
   c. Is updated as needed.

Intent Statements

Effective management of accounts receivables ensures a steady stream of cash that can be invested to earn additional income for the organization.
Examples
Accounts receivables must be analyzed periodically to determine if the receivables are being paid according to the invoice due date. Receivable conversion can vary depending on the type of receivable; generally government reimbursement receivables take longer to collect than private pay. Therefore, the receivable mix will influence your overall days in accounts receivable that are outstanding.

A key financial benchmark of the efficiency of accounts receivable management is “Days in Accounts Receivable.” Refer to the annual publication Financial Ratios & Trend Analysis of CARF-Accredited Continuing Care Retirement Communities, Chapter 3. Liquidity Ratios for a discussion of Days in Accounts Receivable ratio. Ratio Pro has a “Days in Accounts Receivable” ratio against which to benchmark.

Examples of current assets include:
- Cash and current investments.
- Accounts receivables.

Examples of current liabilities include:
- Short-term debt.
- Accounts payable.

Intent Statements
To demonstrate an organization’s commitment to excellence and transparency, the organization fully discloses the financial information contained in the audited financial statements and footnotes.

Examples
Copies could be made available in the marketing office or resident service office. A summary could be made available in the resident newsletter.

1.F. 17. The organization evaluates key performance indicators that include, but are not limited to, contract types identified by:
   a. Level or type of care or service.
   b. Number of residents per contract type.

Intent Statements
Accredited organizations evaluate key financial performance indicators, such as contract type information, to aid in strategic fiscal planning efforts.

1.F. 18. The organization has a mechanism to make the audited financial statements and footnotes available to:
   a. Prospective persons served.
   b. Current persons served.
   c. Other stakeholders.

1.F. 19. The organization conducts a capital needs assessment that:
   a. Addresses:
      (1) Existing capital assets.
      (2) Future capital asset needs.
   b. Is documented.
   c. Is reviewed regularly and updated as needed.

Intent Statements
A capital needs assessment is a valuable guide to understanding the life expectancy and cost of major items needed to maintain and update an organization. It serves as a process to identify, predict, budget, and make critical decisions regarding major upcoming expenditures, maintenance of existing facilities, planned expansions, and associated financing strategies to support such needs (i.e., growth of new assets, debt capacity, etc.). Although a capital needs assessment may involve multiple experts and consider various types of information, the assessment process should result in a document to help the organization identify major capital needs that should be considered for long-range financial planning.

19.c. The organization determines the frequency at which it will review the capital needs assessment to ensure that the information is current.

Examples
19.a. Existing capital assets may include property, plant, and equipment items, such as:
- Bricks and mortar.
- Sidewalks.
- Landscaping.
- HVAC systems.
- Personal computers/servers/electronic medical records.
- Buses and other vehicles.

For each item identified, the following information may be addressed:
- Date put into service.
- Estimated repair/replacement date.
- Estimated cost of repair/replacement.

Building assessment reports may be part of the capital needs assessment.

19.b.–c. Changes in capital needs, the organization’s strategic planning process, and its annual budgeting process may be considered in determining the frequency at which the capital needs assessment is reviewed. This review documents that the budgeting for cash and investments required for the capital needs of the organization is addressed. Cash flow projections include what is required to address upcoming capital spending.

Examples

20.b. The organization reviews how assets are safeguarded and how it is currently managing financial obligations such as debt. The organization can describe its outstanding long-term debt and the approaches it will employ to continue to meet debt obligations. It may use long-term financial projections or projected financial ratios to inform debt management. The organization may have a plan in place for replacing a letter of credit.

20.c. Planning might include approaches such as exploring diversification of the investment portfolio, reviewing long-term investment goals and how they may be impacted by short-term volatility in financial markets, monitoring and tracking the organization’s investment performance and making necessary adjustments in the portfolio, and considering external financial expertise regarding use of various financial products based on the organization’s risk tolerance.

20.d.(3) Other stakeholders may include board members, advisory groups, donors, financial institutions, bondholders, and credit rating agencies.

Intent Statements

To engage in planning that considers both fixed assets and monetary capital, organizations benefit from considering a variety of perspectives and information. Combining the insights gained from the capital needs assessment, looking at the risks associated with the organization’s debt, considering the potential risks of the organization’s investment strategy, and obtaining input from key stakeholders are part of a comprehensive approach to identifying future financial opportunities and challenges.

Examples

20. The organization’s long-range financial planning process considers:

a. The results of the capital needs assessment.

b. Debt management risks.

c. Investment risks.

d. Input from:
   (1) Persons served.
   (2) Personnel.
   (3) Other stakeholders.

21. A long-range financial plan is:

a. Developed:
   (1) Including:
      (a) Timelines for capital asset repair and replacement projects.
      (b) Cash flow projections for capital asset needs.
      (c) Sources of funding to support identified needs related to:
          (i) Fixed asset repair and replacement.
          (ii) Organizational growth.
      (d) Management of debt obligations.
      (e) Management of investment risks.
   (2) That aligns with the organization’s strategic plan.

b. Implemented.
c. Shared, as relevant to the needs of:
   (1) Persons served.
   (2) Personnel.
   (3) Other stakeholders.
d. Reviewed at least annually for relevance.
e. Updated as needed.

Intent Statements

When properly developed and implemented, the long-range financial plan serves as a tool to facilitate future financial performance. It matches the organization's financial resources with the goals and priorities set in the strategic plan addressed in Section 1.C. A well-thought-out long-range financial plan provides the organization with the information needed to make informed strategic and operational decisions. The long-range financial plan should therefore address both maintenance and growth capital, and it should identify the financial instruments being used to meet future needs.

Maintenance capital is typically provided by cash and cash flow. Growth capital may be financed through internal and external sources. Internal sources may include reserves, proceeds from a capital campaign, or other sources; external sources may include various types of debt that could be structured in different ways based on interest rates, maturity/amortization, and other factors.

The intention of the long-range plan is to provide forecasting and projections for multiple years beyond the current annual budget. CARF does not identify a specific timeframe for such planning; organizations should identify their timeframe for “long-range” based on their market.

The long-range financial plan may be a separate document or it may be clearly integrated with the organization's strategic plan. If the long-range financial plan is integrated with the strategic plan, surveyors must be able to easily identify the required written elements of the long-range financial plan within the strategic plan.

Examples

21.a.(1)(a)–(c) Based on the information in the capital needs assessment, organizations identify funding source(s) for estimated costs of repair/replacement.

Projected financial statements are prepared in a format consistent with the organization's annual audited financial statements and include:

- Financial position.
- Activities.
- Cash flow.

21.a.(1)(d) To manage debt, an organization may explore long-range approaches such as reviewing the type of debt it takes on to ensure that it best aligns with organizational needs, prioritizing existing debt payments, or restructuring debt.

21.a.(1)(e) To manage investment risk, an organization may include different asset classes in its investment portfolio; e.g., stocks, bonds, real estate, and cash, to increase the probability that some investments will provide satisfactory returns even if others are flat or losing value. An organization might also diversify by dividing the money allocated to a particular asset class, such as bonds, among various categories of investments that belong to that asset class.

21.c.(3) The organization shares the information in the long-range financial plan, including but not limited to information related to continuing disclosure requirements for public debt and investor relations, with various stakeholders. Other stakeholders might include, but are not limited to, organizational leadership and governance, lending institutions, and credit rating agencies.

21.d. The organization determines the method of review and responsibility for plan updates. Although the long-range financial plan should have some type of review at least annually, it may not need to be updated that frequently because it is long-range in nature. Significant market changes impacting the long-range financial plan could prompt leadership to consider an update.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Annual approved budgets
- Reviews of financial plans
- Financial audits or reviews
- Written procedures for handling the funds of the persons served, if applicable
- Documented reviews of records of persons served
- Fiscal policies
- Financial remediation plans, if appropriate
- Fee schedules, if applicable
- A management letter, if applicable
- Cost analysis of services provided
- Financial reports
- Cash management policies
- Documented review of accuracy of billing and coding of services with the services provided, if applicable
- Investment policy
- Capital needs assessment
- Long-range financial plan

G. Risk Management

Description

CARF-accredited organizations engage in a coordinated set of activities designed to control threats to their people, property, income, goodwill, and ability to accomplish goals.

1.G. The organization implements a risk management plan that:

a. Includes:
   - Identification of loss exposures.
   - Analysis of loss exposures.
   - Identification of how to rectify identified exposures.
   - Implementation of actions to reduce risk.
   - Monitoring of actions to reduce risk.
   - Reporting results of actions taken to reduce risks.
   - Inclusion of risk reduction in performance improvement activities.

b. Is:
   - Reviewed at least annually for relevance.
   - Updated as needed.

Intent Statements

The risk management plan is designed to manage risk and reduce the severity of a loss if one were to occur.

Examples

A risk management plan can include written, action-oriented documents developed with a goal to mitigate, reduce, or eliminate an organization’s potential losses or exposure to risk. The plan may be present and future oriented and identify current risk management priorities and any new measures to be implemented. To maximize the usefulness of the risk management plan, it might be specific in identifying the necessary steps to achieve goals, timelines, and persons responsible for implementation.
There could be seven components that constitute 
an organization’s risk management plan.

1.a.(1) Identify loss exposures—Take inventory of 
threats to all areas of the organization, including 
personnel, property, reputation, income, and 
ability to accomplish mission and goals. These 
areas include internal or external events that 
could expose the organization to litigation, gov-
ernment sanction, property loss, or business 
interruption. Some areas to be considered are:

- Governance—fiduciary responsibility, con-
  flicts of interest.
- Facility/plant/grounds—property loss or 
damage, capital replacement, environmental 
safety, emergency preparedness, life safety 
requirements.
- Financial—billing accuracy, fraud, investment 
risk, accounting practices.
- Human resources—employment laws, work-
er’s compensation, worker’s safety.
- Transportation—accident liability, property 
loss, personal injury.
- Information technology—data integrity, pri-
  vacy of information, system failure, data loss.
- Care process—wounds, falls, injuries, abuse 
or neglect, medication errors, elopement, 
wandering.

1.a.(2) Evaluate and analyze identified loss expo-
sures—Consider the nature of each area of risk. 
What is the likelihood of an adverse event occur-
rting? If an event were to occur, how would it 
impact the organization? Are there certain areas 
of the organization or programming where the 
risk is greater? What factors cause or contribute 
to increased risk exposure?

1.a.(3) Identify how to rectify identified loss expo-
sures—Pinpoint actions that can be taken to 
mitigate, reduce, or eliminate risks. Such actions 
could include policies and procedures, staff 
education and training, practices of verifying 
credentials, safety and performance improve-
ment initiatives, reporting processes, and 
maintenance of adequate insurance coverage.

1.a.(4) Implement actions to reduce risk—Develop 
timelines for action and identify the individual(s) 
responsible for carrying out the actions. This will 
leak accountability for the implementation of risk-reduction strategies. Consider tracking 
methods to assist in verifying implementation 
of the strategies.

1.a.(5) Monitor actions to reduce risk—Establish 
mechanisms and responsibilities for maintaining 
awareness of risk exposure and reduction strate-
gies. Who is responsible for monitoring various 
areas of risk? What types of events should be 
reported and to whom should reports be sub-
mitted? Are individual incidents reported, or 
are indicators tracked monthly or quarterly?

1.a.(6) Report the results of actions taken to reduce 
risk—Determine if the actions taken to reduce 
risk have been effective. Based on information 
received through the established monitoring 
processes, are there any positive or negative 
trends in risk exposure? How and to whom is 
this information communicated?

1.a.(7) Include risk reduction in performance 
 improvement activities—Areas of risk could be 
periodically reviewed as part of continuous 
performance improvement. When the desired 
or necessary results are not achieved, the organi-
zation can complete a new analysis of risk, add 
new or change existing strategies to rectify risk, 
monitor the effects of the changes, and report the 
new results.

2. As part of risk management, the insurance 
package of the organization:

a. Is reviewed:
   (1) For adequacy.
   (2) At least annually.

b. Protects assets.

c. Includes:
   (1) Property coverage.
   (2) Liability coverage.
   (3) Other coverage, as appropriate.

Intent Statements
When effectively managed, insurance, whether 
third-party or self-insurance, can cover many 
tangible risks an organization faces. The organi-
zation’s insurance package includes appropriate 
coverage for any services it may provide in more 
than one state/province or other jurisdiction.
Examples
The organization recognizes that although insurance is only one aspect of an organization’s overall risk management strategy, adequate insurance coverage is essential. The organization’s insurance coverage might include:
- Professional liability.
- Property and loss.
- Fire and flood.
- Business interruption.
- Directors and officers.
- Automotive.
- Cybersecurity.

As an element of risk management, the leadership ensures that coverage is put in place to protect the needs, risks, and assets of the organization. The intent is that the review be conducted with the assistance of someone who is knowledgeable about insurance needs and types of coverage. This may be an insurance broker or anyone else with experience who also knows and is aware of the needs, risks, and assets of the organization.

1.G. 3. The organization implements written procedures regarding communications that address:
   a. Media relations.
   b. Social media.

Examples
Media relations procedures might include who may or may not talk to the media, whom to notify of requests for interviews, whom to contact after hours, use of press releases, or media relations philosophy.
Social media procedures might address the organization’s definition of social media; e.g., Facebook, Twitter, blogs, message boards; acceptable uses of social media; who has access and authority to post or modify information; privacy settings; parameters for communicating with persons served and prospective persons served; protection of health information; and how violations of the procedures will be managed.

1.G. 4. If any of the services delivered by the program seeking accreditation are provided under contract with another organization or individual, documented reviews of the contract services:
   a. Assess performance in relation to the scope and requirements of their contracts.
   b. Ensure that they follow all applicable policies and procedures of the organization.
   c. Ensure that they conform to CARF standards applicable to the services they provide.
   d. Are performed at least annually.

Intent Statements
This standard relates to Standard 2.A.1. in Section 2 on scope of services and applies to contracted personnel, the contracting of any part of an accredited program, and all other contracted services related to service delivery to the persons served by the program(s) seeking accreditation. Refer to the Glossary for the definition of contract.

The organization complies with all applicable legal and regulatory requirements relative to the management of its workforce. This standard applies to independent contractors, as defined by the Internal Revenue Service (www.irs.gov/businesses/small-businesses-self-employed/independent-contractor-self-employed-or-employee), the Canada Revenue Agency (www.canada.ca/en/revenue-agency/services/forms-publications/publications/rc4110/employee-self-employed.html), or similar entities in other countries.

Examples
Reviews of contract services may be conducted by leadership, a contract manager/management office, risk management, human resources, etc.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Risk management plan
- Reports from regulatory agencies
- Reports associated with legal actions
- Performance improvement plans
- Personnel policies manual
- Insurance policies
- Financial reports
- Risk analysis reports
- Written procedures regarding media relations and social media
- Reviews of contracted services

H. Health and Safety

Description

CARF-accredited organizations maintain healthy, safe, and clean environments that support quality services and minimize risk of harm to persons served, personnel, and other stakeholders.

Applicable Standards

When determining applicability, please refer to the Glossary for the definitions and clarification of all italicized terms.

Standards in this subsection apply to all locations of an organization that meet the following descriptions, unless an identified exception applies:

- Locations owned/leased by the organization that are:
  - Used for delivery of the programs or services seeking accreditation.
  - Administrative locations where personnel related to the programs or services seeking accreditation are located.

- Donated locations/spaces that are controlled/operated by the organization and are:
  - Used for the delivery of the programs or services seeking accreditation.
  - Administrative locations where personnel related to the programs or services seeking accreditation are located.

Identified exceptions:

Standards 1.H.5., 1.H.7., 1.H.14., and 1.H.15. are NOT applied to locations that meet any of the following criteria:

- Private homes of persons served.
- Community settings that are not owned/leased or controlled/operated by the organization.
- Used solely by an employee-owner for administration and no other persons or personnel are located, meet, or are served at the location.
1.H. The organization maintains a healthy and safe environment.

Examples
The physical environment of the organization shows evidence of ongoing attention to safe practices, reduction of health and safety risks, and an overall concern for the health and safety of the persons served and personnel. Health and safety requirements are sometimes determined by local or other governmental authorities. Documentation of daily maintenance tasks is not required.

1.H. 2. The organization implements written procedures to promote the safety of:
   a. Persons served.
   b. Personnel.

Intent Statements
Regardless of setting, the organization must demonstrate satisfactory efforts to provide services as safely as possible and promote a safe work environment.

Examples
Written procedures could include the identification of personnel responsible for implementation of health and safety procedures.

1.H. 3. Persons served receive education designed to reduce identified physical risks.

Examples
Classes may be provided or arranged for persons served on emergency preparedness, minimizing trip hazards, crime prevention, or self-defense.

For programs that equip individual units with emergency call or monitoring systems, the program provides education for persons served and their family/support system on the use of these systems addressing topics such as when to use them, what to expect when used, and how to know whether they are in working order.

1.H. 4. Personnel receive documented competency-based training:
   a. At orientation in the following areas:
      (1) Health and safety practices.
      (2) Identification of unsafe environmental factors.
      (3) Emergency procedures.
      (4) Evacuation procedures, if appropriate.
      (5) Identification of critical incidents.
      (6) Reporting of critical incidents.
      (7) Medication management, if appropriate.
      (8) Reducing physical risks.
      (9) Workplace violence.
   b. At least annually in the following areas:
      (1) Health and safety practices.
      (2) Identification of unsafe environmental factors.
      (3) Emergency procedures.
      (4) Evacuation procedures, if appropriate.
      (5) Identification of critical incidents.
      (6) Reporting of critical incidents.
      (7) Medication management, if appropriate.
      (8) Reducing physical risks.
      (9) Workplace violence.

Intent Statements
See the Glossary for the definition of competency-based training.

Examples
Ways to structure training so that they are competency based may include “demonstration and return demonstration” in which the trainer demonstrates a skill (such as using a fire extinguisher
or other equipment) and the trainee performs the same skill in return to ensure competency. Another technique might be to have a written quiz or assessment following a training presentation to ensure that key concepts are understood. Verbal quizzes in which the trainee describes to the trainer the expected response in an emergency may also be useful in assessing competencies.

Some organizations have found it helpful to begin by assigning responsibility for developing a training plan. The plan considers the training and information needs of personnel, contractors, visitors, managers, and those with an emergency response role identified in the plan. The plan identifies:

- Who will be trained.
- Who will do the training.
- What training activities will be used.
- When and where each session will take place.
- What the objectives of each session will be.
- How the session will be evaluated and documented.

Reviews may be conducted after each training activity. Training participants can be involved in the evaluation process.

Some activities organizations may consider using are:

- Orientation and Education Sessions—These are regularly scheduled to allow discussion, provide information, answer questions, and identify needs and concerns.
- Tabletop Exercise—Members of the emergency management group meet in a conference room setting to discuss their responsibilities and how they would react to emergency scenarios. This is a cost-effective and efficient way to identify areas of overlap and confusion before conducting more demanding training activities.
- Walk-Through Drill—The emergency management group and response teams actually perform their emergency response functions. This activity generally involves more people and is more thorough than a tabletop exercise.
- Functional Drills—These drills test specific functions such as medical response, emergency notifications, and warning and communication procedures and equipment, though not necessarily at the same time. Personnel are asked to evaluate the systems and identify problem areas.
- Evacuation Drills—Personnel walk the evacuation route to a designated area where the procedures for accounting for all personnel are tested. As they evacuate, participants are asked to make notes of things they notice that might become possible hazards during a real emergency evacuation, such as stairways cluttered with debris or inadequate lighting in the hallways.
- Full-Scale Exercise—A real-life emergency situation is simulated as closely as possible. This exercise involves the organization's emergency response personnel, employees, the management, and community response organizations.

Employee Training—General training for all employees addresses:

- Individual roles and responsibilities.
- Information about threats, hazards, and protective actions.
- Notification, warning, and communication procedures.
- Means for locating family members in an emergency.
- Emergency response procedures.
- Evacuation, shelter, and accountability procedures.
- Emergency shutdown procedures.

The scenarios developed during the vulnerability analysis can serve as the basis for training events. 4.a.(9) and 4.b.(9) Training might include what types of behaviors, actions, or communication constitute workplace violence; e.g., bullying; intimidation; sexual harassment; disruptive behavior; assaultive behavior; or unauthorized possession and/or use of a weapon such as a gun, knife, Taser, or bomb. Training may also include actions to take under such circumstances; e.g., communication with the offending party, the
mechanism to seek assistance within the organization, and reporting requirements.

1.H. 5. There are written emergency procedures:
   a. For:
      (1) Fires.
      (2) Bomb threats.
      (3) Natural disasters.
      (4) Utility failures.
      (5) Medical emergencies.
      (6) Violent or other threatening situations.
   b. That satisfy:
      (1) The requirements of applicable authorities.
      (2) Practices appropriate for the locale.
   c. That address, as follows:
      (1) When evacuation is appropriate.
      (2) Complete evacuation from the physical facility.
      (3) When sheltering in place is appropriate.
      (4) The safety of all persons involved.
      (5) Accounting for all persons involved.
      (6) Temporary shelter, when applicable.
      (7) Identification of essential services.
      (8) Continuation of essential services.
      (9) Emergency phone numbers.
      (10) Notification of the appropriate emergency authorities.

Examples

Depending on the type of emergency, the procedure could include immediate response, evacuation, use of appropriate suppression techniques, notification of the proper authorities, sheltering in place, and reporting requirements. In developing emergency procedures the organization identifies critical products, services, and operations that may be impacted in an emergency and backup systems, internal capabilities, and external resources that may be needed or accessed.

5.a.(3) The organization evaluates safety concerns related to possible natural disasters and their potential effects on the organization’s staff members, the persons served, and property and develops procedures detailing action to be taken in the event of occurrence of a natural disaster. Possible natural disasters are those typical of a particular geographic location. They may include tornadoes, severe rainstorms, hurricanes, floods, earthquakes, blizzards, ice storms, snowstorms, landslides, and volcanic eruptions.

5.a.(4) Procedures for utility failures may include use of an emergency generator system; emergency lighting systems; battery-operated flashlights, lanterns, or lamps; cell phones; and a contract with a vendor to supply bottled water.

5.a.(5) Medical emergencies might include someone unable to get up from a fall; a severe cut or allergic reaction; loss of consciousness due to a change in blood pressure, stroke, cardiac event, or medication misuse; or severe emotional distress that may contribute to suicide risk.

5.a.(6) Violent or other threatening situations may include explosions, gas leaks, biochemical threats, acts of terrorism, use of weapons, and aggressive or assaultive behaviors of persons served, personnel, or visitors.
5.c. Evacuation may be addressed in a separate procedure or incorporated into relevant emergency procedures such as those for fire and bomb threats. The procedures identify when evacuation versus sheltering in place is appropriate. The procedures address the entire spectrum of an evacuation, including an evacuation when evacuees cannot return to the facility. The procedures for evacuation identify the responsibilities of personnel who may assist in the process of evacuation.

Procedures include a predetermined site for the gathering of all individuals upon evacuation. The evacuation plan considers not only the possible physical barriers of the facility, but also the individualized needs of those to be evacuated, such as persons with mobility impairments who will need assistance, or persons with cognitive, hearing or visual impairments. The temporary shelter considers the unique health, safety, and accessibility needs of persons served, to the extent possible. Procedures identify protocol to follow in the event that an incident may require movement to a temporary shelter.

Procedures include the process for notifying personnel if individuals are not present. Procedures may include protocols that provide direction to personnel if services will be curtailed.

5.c.(7)–(8) Essential services may include services, products and operations necessary to maintain the health and safety of the persons served such as availability of medications and medical devices, communication systems, and systems for operation of essential business operations such as information support and payroll systems. Procedures identify internal and external resources and responsibilities for ensuring the continuation of essential services.

5.c.(9) Emergency phone numbers might include emergency call lists; contact numbers for family/support systems of the persons served; organizations that will provide temporary shelter or accept transfer of persons served; transportation companies; and resources such as hospitals, utilities, and suppliers of emergency equipment.

Resources

Local Red Cross associations, state/provincial or other jurisdictional regulations, regional disaster preparedness groups, and many websites offer current and useful information in the development of emergency plans.

The Federal Emergency Management Agency (FEMA) is a national resource for education, training, and emergency information in the U.S. FEMA has established an emergency planning guide for business and industry that provides advice for creating and maintaining an overall emergency management plan specific to each organization’s corporate culture. Other free emergency procedures that may be incorporated into your plans are also available online. Resources include:

- [www.ada.gov/emergencyprepguide.htm](http://www.ada.gov/emergencyprepguide.htm)

Other websites that offer resources for developing emergency procedures include:

- Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers:
  - [https://asprtracie.hhs.gov/cmsrule](https://asprtracie.hhs.gov/cmsrule)

The organization has evacuation routes that are:

- Accessible.
- Understandable to:
  - Persons served.
  - Personnel.
  - Other stakeholders, including visitors.

Examples

- Evacuation routes refer to the clearly visible and known routes of egress. Signage such as a posted map or diagram is not required. If an organization chooses to use signage, this may be simple Exit signs over doors, Braille representation, diagrams, or directional signs showing corridors and line of travel to exit doors. Accessibility of the signage would consider location, height, and other needs relative to the persons served and other stakeholders. Additionally, the exit ways should have adequate lighting and be clear of obstructions such as equipment, furniture or locked doors. Evacuation routes should not result in individuals getting to an unsafe location such as ungraded land, a rooftop with no opportunity for egress, or where emergency personnel cannot reach the individuals.

- An unannounced test of each emergency procedure:
  - Is conducted at least annually:
    - On each shift.
    - At each location.
  - Includes, as relevant to the emergency procedure, a complete actual or simulated physical evacuation drill.
  - Is analyzed for performance that addresses:
    - Areas needing improvement.
    - Actions to address the improvements needed.
    - Implementation of the actions.
(4) **Necessary education and training of personnel.**

(5) **Whether the actions taken accomplished the intended results.**

d. **Is evidenced in writing, including the analysis.**

**Intent Statements**

It is expected that each emergency procedure addressed in Standard 1.H.5. (fires, bomb threats, natural disasters, utility failures, medical emergencies, and violent or other threatening situations) is tested, analyzed for performance, and documented, including the analysis. Practicing emergency procedures helps the persons served and personnel to better respond in actual emergency situations. Simulated evacuations should be limited to situations where actual evacuations are not possible. Emergency procedure testing is part of an organization’s performance improvement activities. Analysis of results of the tests may indicate ways to improve performance.

**Examples**

Emergency tests may be done in a variety of ways. There can be a drill that simulates emergency procedures for persons served and personnel. Actual physical tests or drills that move personnel through the procedure allow for practice and provide an indication of how personnel might respond in an actual emergency. With the exception of evacuation drills, tests of the emergency procedures could also be accomplished with unannounced written tests that detail what should be done in the event of an actual emergency. All personnel who would be expected to participate in an emergency procedure should be included in the testing. The emergency procedure testing is used to improve the knowledge and readiness of personnel in the event of actual emergency situations.

During these tests, the persons served may be involved in the emergency evacuation. If persons served are not involved in the test, personnel simulate the types of restrictions that persons served may have during an evacuation when actually moving through the process of evacuation.

An organization may establish a benchmark or target prior to the test. Many times this is met and no improvement is needed. This confirms that current practice is appropriate.

Use of a grid to track tests of all emergency procedures may help facilitate completion of all tests at least annually at all locations and on all shifts.

1.H. **8.** If an organization provides services in locations that are not owned/leased or controlled/operated by the organization, it implements written procedures that address safety at the service delivery site:

a. **For:**

   (1) Persons served.

   (2) Personnel.

b. **Including:**

   (1) Consideration of any emergency procedures that may already be in place at the service delivery site.

   (2) The physical environment, including accessibility, of the service delivery site.

   (3) Basic needs in the event of an emergency.

   (4) Actions to be taken in the event of an emergency.

   (5) Provisions for communication by personnel while providing services regarding decisions to continue or discontinue services.

**Intent Statements**

Please see the Glossary for a definition of controlled/operated.

Written procedures address the uniqueness of the settings and types of situations that may be encountered, and when decisions need to be made, potentially on an immediate basis, to ensure the safety of persons served and personnel under a variety of circumstances.

This standard applies to programs that include community outings or community integration activities for the persons served and to programs that provide all of their services in locations that
are not owned/leased or controlled/operated by the organization, including private homes.

8.b.(1) If services are provided in a location that is separately licensed or regulated, there may already be emergency procedures in place. If personnel or persons served are present in the event of an emergency, they would follow those procedures.

Examples

Services may be provided at sites including, but not limited to, a library, school, sports or performing arts venue, movie theatre, volunteer site, job site, private home, etc. Based on the service delivery site, the organization considers actions to be taken in the event of emergencies such as fires, bomb threats, natural disasters, utility failures, medical emergencies, and violent or other threatening situations.

9. There is ready access to:
   a. First aid expertise.
   b. First aid equipment.
   c. First aid supplies.
   d. Relevant emergency information on the:
      (1) Persons served.
      (2) Personnel.

Intent Statements

It is important to provide a safe setting for the persons served and personnel. The adequacy of first aid expertise reflects the needs of the population served and the service setting. Necessary emergency resources, including people trained to respond and the location of first aid equipment and supplies, are known and quickly available during program hours. First aid supplies are checked for expiration and availability of adequate supply through a systematic process and replenished and replaced as needed.

9.d. The organization has a mechanism in place to ensure that emergency information is kept current on persons served and personnel.

Examples

The organization defines how it will have ready access to first aid. This may be accomplished by training key personnel in first aid. If in a hospital setting, hospital personnel within the program/service site could be used, or an external emergency response team (e.g., 911) could be called.

It is critical to have emergency information on the persons served and personnel readily available in the event that, during an emergency, the building could not be reentered or an emergency situation occurs in which information is needed immediately. Many organizations have a portable file with critical information. An organization may also be able to use existing personnel files and records of the persons served if these would be readily accessible in an emergency.

The adequacy of first aid expertise reflects the needs of the population being served as well as the services setting and may include first aid, CPR, standard precautions, or other safety training.

First aid and CPR classes are available from local agencies such as the Red Cross, the YMCA, and various other service organizations. The organization may choose to have designated personnel become trainers in first aid and CPR, or it may contract with other agencies to provide training.

10. The organization implements written procedures regarding critical incidents that include:
    a. Prevention.
    b. Reporting.
    c. Documentation.
    d. Remedial action.
    e. Timely debriefings conducted following critical incidents.
    f. The following critical incidents:
       (1) Medication errors.
       (2) Use of seclusion.
       (3) Use of restraint.
       (4) Incidents involving injury.
       (5) Communicable disease.
       (6) Infection control.
       (7) Aggression or violence.
       (8) Use and unauthorized possession of weapons.
       (9) Wandering.
       (10) Elopement.
Section 1.H. Health and Safety

(11) Vehicular accidents.
(12) Biohazardous accidents.
(13) Unauthorized use and possession of legal or illegal substances.
(14) Abuse.
(15) Neglect.
(16) Suicide and attempted suicide.
(17) Sexual assault.
(18) Overdose.
(19) Other sentinel events.

Intent Statements
An organization should consider the persons served, personnel, and other stakeholders, such as visitors to its program, in developing its procedures for critical incidents. Although an organization is expected to have procedures that include all of the types of critical incidents listed in this standard that are applicable to its operations, it would be possible for a procedure to adequately address more than one type of critical incident. An organization is not required to have a separate procedure for each type of incident as long as all critical incidents are appropriately considered.

Examples
The organization ensures that it follows legal requirements regarding the reporting of incidents to the proper authorities. The terminology used in Canada may be serious occurrences. Reporting requirements can be obtained from licensing agencies, protection and advocacy services, and funding sources.

The organization may have written procedures in separate or combined documents.

10.f.(13) In its written procedures the organization addresses the possession and use of medical marijuana, including topics such as whether it is legal or illegal, how it is managed, the impact of its use on other persons served, and sharing with or selling to other persons served.

1.H. 11. A written analysis of all critical incidents is provided to or conducted by the leadership:
   a. At least annually.
   b. That addresses:
      (1) Causes.
      (2) Trends.
      (3) Areas needing improvement.
      (4) Actions to address the improvements needed.
      (5) Implementation of the actions.
      (6) Whether the actions taken accomplished the intended results.
      (7) Necessary education and training of personnel.
      (8) Prevention of recurrence.
      (9) Internal reporting requirements.
      (10) External reporting requirements.

Intent Statements
An integrated approach to the management of critical incidents is essential to effective risk management.

Examples
If critical incidents are analyzed at the level of the larger entity or organization, there is still a process to review, analyze, and address the data associated with critical incidents specific to the programs/services seeking accreditation. Analyzing critical incidents at the level of the program/service could identify program/service specific causes, trends, actions, prevention of recurrence, and education needs that may differ from the rest of the organization. The written analysis might be a separate report or contained within the organizationwide report.

This report is a critical piece of information in both risk management and performance improvement activities. A critical component is the concept of prevention. Changing the environment, attitudes, and service delivery techniques are all part of the process, but if the organization is not committed to the prevention of incidents, the improvement will not last.
The organization may be analyzing critical incidents monthly, quarterly, or even more frequently. However, this standard prompts the organization to look back throughout the year to identify trends or issues for performance improvement.

1.H. The organization implements procedures:
   a. For:
      (1) Infection prevention.
      (2) Infection control.
   b. That include:
      (1) Training regarding:
         (a) Infections.
         (b) Communicable diseases.
      (2) Appropriate use of standard or universal precautions.
      (3) Guidelines for addressing these procedures with:
         (a) Persons served.
         (b) Personnel.
         (c) Other stakeholders.

Intent Statements
The persons served, personnel, and other stakeholders should be provided with training based on individual needs. Each organization is encouraged to check legal and regulatory requirements regarding the use of standard or universal precautions in the programs provided and with the populations served.

1.H.12. In Canada this may be referred to as routine practices.

Examples
The organization could provide staff education on universal precautions, handwashing technique, the use of alternative cleansing solutions, or the use of aseptic techniques. Posted signs, items in the newsletter, or other means could be used to educate family members, volunteers, and other visitors about preventing the spread of infection. The organization could have surveillance activities for monitoring and trending acquired infections. A written infection control plan and other policies could be developed to include surveillance, isolation and precautions, health of persons served, employee health, education, antibiotic usage and resistance, and HIV-related issues.

Resources
Resources used in the development of infection control procedures could include the Centers for Disease Control and Prevention (www.cdc.gov/infectioncontrol/index.html), the Association for Professionals in Infection Control and Epidemiology (www.apic.org), the Public Health Agency of Canada (www.phac-aspc.gc.ca), Infection Prevention and Control Canada (www.ipac-canada.org), or state/provincial or other jurisdictional departments of health outbreak manuals.

Resources specific to hand hygiene include:
- Infection Prevention and You: http://professionals.site.apic.org
- Centers for Disease Control and Prevention Hand Hygiene in Healthcare Settings: www.cdc.gov/handhygiene/index.html

Applicable Standards
Standard 1.H.13. applies only to programs that provide transportation for the persons served.

Note: This standard does not apply to vehicles used only for transporting materials.

1.H. 13. When transportation is provided for persons served there is evidence of:
   a. Appropriate licensing of all drivers.
   b. Regular review of driving records of all drivers.
   c. Insurance covering:
      (1) Vehicles.
      (2) Passengers.
   d. Safety features in vehicle(s).
   e. Safety equipment.
   f. Accessibility.
g. Training of drivers regarding:
   (1) The organization’s transportation procedures.
   (2) The unique needs of the persons served.

h. Written emergency procedures available in the vehicle(s).

i. Communication devices available in the vehicle(s).

j. First aid supplies available in the vehicle(s).

k. Maintenance of vehicle(s) owned or operated by the organization according to manufacturers’ recommendations.

l. If services are contracted, a review of the contract at least annually against elements a. through k. of this standard.

Intent Statements

Transportation for the persons served is provided in a safe manner consistent with the regulations of the local authorities. This standard will apply when any vehicle, including a personal vehicle, is used to provide transportation for persons served.

13.j. First aid supplies are checked for expiration and availability of adequate supply through a systematic process and replenished and replaced as needed.

13.l. See the Glossary for the definition of contract.

Examples

This standard is not applied to public transportation services that the person served may use; for example, city taxis, Uber, Lyft, Para-transport from the city, city buses, etc. The organization may have a phone available for people to arrange these types of services to facilitate their transportation needs.

If persons served pay the program seeking accreditation for the transportation service (either as a fee for service or as part of their agreement for services) this standard applies. If persons served pay a driver or transportation company directly, this standard is not applicable to the program seeking accreditation.

13.a. Verification of driver’s licenses occurs on all personnel, including volunteers, who provide transportation for the persons served.

13.d.–e. The intent of these standards includes the use of age-appropriate restraining devices to be secured in the vehicles. Height, weight, cognition, etc., need to be taken into consideration.

Road hazard equipment is secured in a specific location in the vehicle. The equipment might include a flashing light, portable red/yellow reflector warning device, or road signs that can be placed outside the vehicle.

13.g. Drivers are trained in assisting passengers who have a variety of needs in order to make the vehicles accessible to them. This may include training in wheelchair management, providing seating assistance, and securing passengers once in the vehicle.

13.h. The written procedures for handling emergencies include roadside emergencies and individual emergencies that may occur during operation of the vehicle.

13.j. If personal vehicles are used to transport persons served, the organization might consider stocking a safety bag or kit with supplies that could be picked up whenever a personal vehicle is used.

A standard first aid kit is on board. A routine check of the supplies in the kit is done and recorded so that the kit always contains the necessary items.

Resources

- National Aging and Disability Transportation Center: www.nadtc.org

14. Comprehensive health and safety self-inspections:

   a. Are conducted at least semiannually on each shift.

   b. Result in a written report that identifies:

      (1) The areas inspected.

      (2) Recommendations for areas needing improvement.

      (3) Actions taken to respond to the recommendations.
Intent Statements

Regular self-inspections help personnel to internalize current health and safety requirements into everyday practices. Self-inspections must include all facilities regularly utilized by the organization.

Examples

A self-inspection is defined as one that is conducted by individuals or groups within the organizational structure. Many organizations have an ongoing review of their environment for safety. The standard is a minimum threshold. These reviews, as well as the external review, are addressed in the organization's performance improvement activities if performance issues are identified. If something is found to be in need of correction, an action plan is developed, implemented, and then reviewed for accomplishment of the stated target. Personnel conducting self-inspections should have appropriate safety knowledge and be provided with a checklist or some other means of identifying which locations, equipment, and supplies have been inspected, along with supporting documentation of the results of the inspection.

Programs that have individual units which they equip with emergency call or monitoring systems, such as a pull cord system, pendant system, or a system in which a phone is knocked off the hook and automatically alerts a call center, may include in their self-inspections a process to ensure that such systems are in working order.

1.H. 15. Comprehensive health and safety inspections:
   a. Are conducted:
      (1) At least annually.
      (2) By a qualified external authority.
   b. Result in a written report that identifies:
      (1) The areas inspected.
      (2) Recommendations for areas needing improvement.
      (3) Actions taken to respond to the recommendations.

Intent Statements

External inspections are completed at least annually to enhance and maintain the organization's health and safety practices. External inspections must include all facilities regularly utilized by the organization.

15.a.(1) This inspection may be conducted in a single, uninterrupted process that moves methodically and comprehensively through an entire program area or physical location, or the organization may have several external inspections conducted that together constitute a comprehensive inspection of all areas relevant to the operation of its programs or services.

Examples

A written report identifies what was inspected, issues that were discovered during the inspection, and an action plan that supports improvement. If the programs and services are part of a larger entity, inspectors may already be inspecting the facility. The organization's safety personnel should be advised of what needs to be inspected so that it can be part of all the safety inspections that the overall organization completes.

When the program is provided by a unit of a larger entity, such as a health system, parent corporation, management contract, or CCRC, the larger entity's safety engineers or other personnel are not considered external authorities. External authorities may include, but are not limited to:

- A licensed or registered safety engineer.
- A representative of an agency that provides an OSHA-type inspection.
- An engineer involved in industrial operations.
- A plant engineer familiar with the types of programs being provided.
- A safety specialist familiar with the types of programs being provided.
- An architect familiar with the types of programs being provided.
- A safety consultant who represents the organization's fire insurance carrier.
- A safety consultant who represents the organization's workers' compensation carrier.
- A safety consultant who is in private practice.
An industrial health specialist.

A representative of the state/provincial fire marshal’s office.

A local fire control authority.

A technical assistance consultant in safety.

In Canada, this could include a representative from a provincial or territorial body designated under legislation related to workplace safety.

A technical assistance consultant in health.

A risk management specialist.

Areas covered in these inspections relate to the types of programs and services that the organization provides.

15.b. The report may be a single consolidated document or it may consist of multiple documents that each clearly identify the areas inspected, recommendations for improvement, and actions to be taken. An organization may have inspections performed by several outside authorities.

16. The organization implements written procedures concerning hazardous materials that provide for safe:

   a. Handling.
   b. Storage.
   c. Disposal.

Examples

Hazardous materials could include biohazardous substances, bodily fluids, industrial-strength cleaning supplies, oil-based paints, fluorescent light bulbs, copier toner, and computer monitors.

Written procedures may include appropriate labeling of containers to promote safe handling, storage, and disposal of hazardous materials.

Resources

- Dispose My Meds: [www.disposemymeds.org](http://www.disposemymeds.org)

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Health and safety policies and procedures
- Health and safety training information
- Inspection report from an external authority and corrective actions, if any recommendations were noted
- Self-inspection reports and follow-up, including response to recommendations
- Written emergency procedures
- Written evidence of unannounced tests of emergency procedures and corrective actions, if any recommendations were noted
- Written incident procedures and copies of incident reports
- Written procedures that address safety of persons served and personnel when services are provided in locations that are not owned/leased or controlled/operated by the organization
- Documentation showing all incidents are reviewed and analyzed to identify trends and an action plan established to reduce risks
- Records of training for staff on incident reporting
- Infection prevention and control procedures
- Medication management procedures, if applicable
- Procedures for the use of standard or universal precautions
- Documentation of provision of competency-based safety training for personnel
- Minutes of safety committee meetings
- A list of personnel trained in safety techniques
- A list of personnel and others on the safety committee
I. Workforce Development and Management

Description
CARF-accredited organizations demonstrate that they value their human resources and focus on aligning and linking human resources processes, procedures, and initiatives with the strategic objectives of the organization. Organizational effectiveness depends on the organization’s ability to develop and manage the knowledge, skills, abilities, and behavioral expectations of its workforce. The organization describes its workforce, which is often composed of a diverse blend of human resources. Effective workforce development and management promote engagement and organizational sustainability and foster an environment that promotes the provision of services that center on enhancing the lives of persons served.

1. The organization documents the composition of its workforce, including all human resources involved in the delivery, oversight, and support of the programs/services seeking accreditation.

Intent Statements
A written description of the composition of the workforce provides the basis for subsequent standards in this section. It is not expected that the organization provide specific numbers or percentages, but rather a general description of the groups that comprise its workforce. Such groups include full-time employees, part-time employees, contractors, independent contractors, per diem workers, remote workers, volunteers, peer support specialists, students, and any other groups or categories of workers involved in the delivery, oversight, and support of the programs/services seeking accreditation.
Section 1.I. Workforce Development and Management

1.I. Workforce development and management practices reflect the organization’s:
   b. Culture.
   c. Person-centered philosophy.
   d. Performance measurement and management system.
   e. Risk management plan.
   f. Strategic plan.

Intent Statements
A strategic approach to workforce development and management contributes to organizational effectiveness. For an organization to implement its mission, strategy, and philosophies, as well as practice within its culture, it requires a workforce that is committed to these concepts. Selection and orientation of the workforce and its development and management are all critical to the overall success of the organization.

This standard relates to a number of others in Section 1 including, but not limited to, Standard 1.A.3.a. on establishment of the organization’s mission and direction; 1.A.5. on cultural competency and diversity; 1.A.2. on person-centered philosophy; 1.M.1.–10. and 1.N.1.–4. on performance measurement, management, and improvement; 1.G.1.–4. on risk management; and 1.C.1.–3. on strategic planning.

2.b. Culture relates to the diversity of the workforce and the culture of the organization as a whole.

Examples
Discussions of the organization’s mission, culture, philosophy, and plans are embedded throughout its workforce development and management practices. As important cornerstones of the organization, these topics are reinforced throughout:
- Recruitment, selection, orientation, and ongoing training and development activities.
- Written and verbal communications.
- Efforts to seek input and feedback from persons served, the workforce, and other stakeholders for planning and improvement purposes.
- Knowledge of how each individual contributes to decreasing risks, increasing the value of the services delivered, and advancing the organization’s strategic direction.

1.I. Ongoing workforce planning includes:
   a. Workforce analysis.
   b. Written job descriptions.
   c. Review and update of written job descriptions in accordance with organizational needs and/or the requirements of external entities.
   d. Recruitment.
   e. Selection.
   f. Retention.
   g. Succession planning.

Intent Statements
Workforce planning is the strategic alignment of an organization’s workforce with its goals and operational plans. Regardless of the size of the organization, the purpose of workforce planning is to ensure that the organization has the right people with the right skills at the right time.

3.a. Workforce analysis is the process of analyzing the current workforce: determining future workforce needs: identifying the gaps between the present and the future; and implementing solutions that will allow the organization to accomplish its mission, goals, and objectives.

3.b. Job descriptions outline duties, responsibilities, competencies, and requirements of a particular job. They are essential in the development of programs to recruit, select, compensate, train, and assess the performance of current and future members of the workforce.

3.c. The organization determines the frequency at which job descriptions are reviewed and updated based on the needs of the organization or other external requirements. Members of the workforce are aware of their job descriptions and may provide input into changes.

3.d. Recruitment is the activity of identifying and soliciting individuals, either from within or outside of the organization, to fill current vacancies or areas of anticipated growth. Individuals with
knowledge of the position(s) being recruited for have input into recruitment plans and activities. Often considered part of recruitment, sourcing is proactive searching for qualified job candidates for current or planned open positions at an organization. Sourcing may identify and collect relevant information on candidates who are actively searching for jobs (active job seekers) and candidates who are not actively looking for job opportunities (passive job seekers).

3.e. Selection involves activities related to choosing people who have the right qualifications to fill a current or future job opening.

3.f. Retaining a qualified and engaged workforce has a direct impact on the organization’s ability to achieve its mission. Retention programs play an important role in attracting and retaining key members of the workforce and in reducing turnover and its related costs.

3.g. Succession planning identifies actions to be taken by the organization should key members of the workforce be unavailable to perform their duties due to retirement, resignation, serious illness, death, or other reasons. Succession planning may be formal or informal depending on the needs of the organization.

Examples

3.d. Job seekers might be located by sourcing job boards, social media sites, and alumni associations and through all types of networking; e.g., relationships with high schools, colleges, and professional associations.

3.f. Retention strategies may include a culture that values the workforce; competitive wages; career ladders; opportunities to participate in special projects; offering activities and resources that are meaningful to the workforce, such as wellness programs, child care, elder care, and continuing education/tuition support; flexible scheduling; and telecommuting.

1.I. The organization implements written procedures that address:

a. Verification of:

   (1) Backgrounds of the workforce in the following areas, if required:
       (a) Criminal checks.
       (b) Immunizations.
       (c) Fingerprinting.
       (d) Drug testing.
       (e) Vulnerable population checks.
       (f) Driving records.

   (2) The credentials of all applicable workforce (including licensure, certification, registration, and education):

       (a) With primary sources.
       (b) When applicable, in all states/provinces or other jurisdictions where the workforce will deliver services.

   (3) Fitness for duty, if required.

b. Actions to be taken in response to the information received concerning:

   (1) Background checks.
   (2) Credentials verification.
   (3) Fitness for duty.

c. Timeframes for verification of backgrounds, credentials, and fitness for duty, including:

   (1) Prior to the delivery of services to the persons served or to the organization.
   (2) Throughout employment.

Intent Statements

The organization is prepared to demonstrate how each of the areas listed is verified. CARF expects that the organization will follow all of the procedures and timeframes that the organization has established and that it will comply with all applicable legal requirements in determining its procedures.

4.a.(1) The organization is aware of and adheres to any external requirements (e.g., of funders, regulatory entities, contractual agreements, etc.) for background checks of its workforce and any requirements it may have established internally. The organization determines whether it will conduct background checks in more than one state/province or jurisdiction for all or select members of the workforce.

Related to background checks for organizations in the U.S. that receive federal funding, Standard 1.A.7.b. addresses implementation of a procedure
to identify exclusion of individuals and entities from federally funded healthcare programs.

4.a.(2)(a) Primary source verification can occur when credentials are initially earned; at the time of hire; or, for existing members of the workforce, prior to an accreditation survey. Verbal, written, or electronic confirmation of credentials (including degrees) from state/provincial or other jurisdictional boards, schools or institutions, and/or trade associations or verification through a credentials verification organization is required. Copies of credentials provided directly by personnel do not meet the primary source verification requirement.

High school diplomas do not need primary source verification, but college degrees, when required for the position, would need to be verified with primary sources. When a licensing authority requires and verifies the education required for the license, evidence of licensing from the licensing authority as the primary source will also serve as evidence that the education has been verified.

4.a.(2)(b) If services are delivered in more than one state/province or jurisdiction, the organization is knowledgeable about reciprocity of credentials such as licensure, certification, or registration and how this would impact in-person service delivery or service delivery via information and communication technologies.

4.a.(3) A fitness-for-duty exam is a medical examination used to determine whether a worker is physically or psychologically able to perform the essential functions of the job.

4.b. The organization has procedures in place in the event that backgrounds, credentials, or fitness for duty cannot be verified.

4.c. Timeframes are established by external authorities or, in their absence, by the organization.

Examples

4.a.(1)(e) Vulnerable population checks might include verifications through an elder abuse database, adult protective services, child protective services, or a sex offender registry.

4.a.(1)(f) Verification might address:
- Whether a driver’s license is current.
- Whether a driver’s license is the right classification for the vehicle and type of driving the person will be doing for the organization; e.g., transporting persons served, driving to deliver services in the homes of persons served or in the community or to meet stakeholders, and driving the organization’s van or the person’s own vehicle.
- Whether there are violations on the driving record.
- Proof of insurance.

4.a.(2) Procedures may include use of a standard form or checklist to document verification of credentials and other relevant information about an individual. Documentation obtained by the organization may include:
- An original letter or copy of a letter from the appropriate credentialing, licensing, or certification board.
- A copy of the license or certification provided by the credentialing organization.
- A phone log or other notation made by an individual responsible for conducting primary source verification.
- A copy of a webpage listing (for those situations where verification is completed online or through the internet by checking a listing of licensed/certified personnel).

4.c.(2) The organization may conduct verifications throughout employment at times such as transfer to a new position, the addition of new job responsibilities, pending expiration of a current license or certification, newly acquired credentials, or return to work after an injury or illness.

Resources

A resource for information on medical license portability in the U.S. is https://imlcc.org.
5. Onboarding and engagement activities include:
   a. Orientation that addresses the organization’s:
      (1) Mission.
      (2) Culture.
      (3) Person-centered philosophy.
      (4) Performance measurement and management system.
      (5) Risk management plan.
      (6) Strategic plan.
      (7) Workforce policies and procedures.
   b. On-the-job training.
   c. Position roles and responsibilities.
   d. Position performance expectations.
   e. Communication systems and expectations.

Intent Statements
5.a. This standard addresses organization-level orientation topics, which are typically supplemented by program/service and/or position-specific topics addressed in other sections of the standards manual.

Examples
5.a.(4) Orientation to performance measurement and management might address:
- The terminology of performance measurement and management.
- Roles and responsibilities in implementing the performance measurement and management system, such as completing assessment tools from which data are gathered, collecting data, analyzing data, participating on performance improvement teams, or working in a quality department that has overall responsibility for performance management and quality.
- How performance information is used by the organization, including review implementation of its mission and core values, improve the quality of its programs and services, facilitate organizational decision making, review and update its strategic plan, and communicate business and service results to stakeholders.

5.b. On-the-job training may include mentoring for individuals who have limited or no experience in a program area by more experienced individuals. Such collaboration focuses on activities designed to facilitate learning of the required competencies. Consideration is given to the intensity of the collaboration (e.g., side-by-side collaboration, on-site collaboration, collaboration via telephone), the length of the collaboration (e.g., one week, one month, several months), and whether it is necessary to have the collaboration conducted by an individual of a specific discipline.

5.d. Position performance expectations could relate to the competencies required of the position; scheduling expectations, such as working weekends or rotating shifts; supervision of others, such as new team members, students, or volunteers; business travel; or use of technology.

5.e. Communication systems and expectations might address:
- Mechanisms used throughout an organization, such as an intranet system used to communicate policies, procedures, and job aids; personal use of organizational email; appropriate use of the organization’s social media channels; and use of personal devices to access organizational information and resources.
- Mechanisms used to communicate information about the persons served. Refer to Standard 2.A.6.
- Expectations for maintaining confidentiality and privacy.
- Expectations for maintaining current personal and emergency contact information.

6. The organization promotes engagement through respect for all individuals in the workforce, including:
   a. Open communication.
   b. A value-driven focus.
c. Initiatives that address:
   (1) Recognition.
   (2) Compensation.
   (3) Benefits.

d. Policies and written procedures that:
   (1) Address, at a minimum:
      (a) Mechanism(s) to provide favorable and constructive feedback.
      (b) Mechanism(s) to address concerns.
      (c) Job postings.
      (d) Promotion.
      (e) Disciplinary action.
      (f) Separation.
      (g) Labor relations, if applicable.
      (h) Prevention of harassment.
   (2) Are accessible to the workforce.

Intent Statements

Workforce engagement refers to the level of an individual’s commitment and connection to an organization. High levels of engagement promote workforce retention, foster loyalty, and improve organizational performance and value.

6.a. Open communication is characterized by a mutual exchange of information and ideas, transparency, and access to people and information.

6.b. Refer to the Glossary for a definition of value.

6.d. This standard does not require that each individual be given a copy of the policies and written procedures, but it does require that each individual has access to the policies and written procedures and that there is notification of when there are changes to policies and procedures that the workforce should be aware of. Evidence that the policies and written procedures are provided or available does not have to be in writing.

Review of the workforce policies is part of the review of the organization’s policies addressed in Standard 1.A.3.k.

6.d.(1)(b) The intent of this standard is that all individuals in the workforce have access to an identified mechanism through which they may express concerns.

6.d.(1)(c)–(d) When a job is available, individuals in the workforce know where it will be posted and are clear on whether there is a possibility of promotion from within the organization.

Examples

6.a. Open communication in an organization may be demonstrated through regular meetings at which important topics and updates are shared, newsletters, suggestion boxes, management rounds, open-door policies, and opportunities to provide input into the plans and activities of the organization.

6.c.(1) Examples of recognition initiatives include employee of the month or year awards, opportunities to earn additional time off or entry into a gift drawing as incentives to complete certain activities, participation in special projects, career ladders, goal-sharing programs, and personal recognitions on anniversaries or for a job well done.

6.d.(1) Policies and written procedures might address:

- Mechanisms to provide feedback, such as a suggestion box, forums with leadership, an open-door policy of leadership, or an annual workforce satisfaction survey.

- Workforce grievance procedures; how to deal with allegations of violations of ethical codes (related to Standard 1.A.6.b.); and how to deal with allegations of waste, fraud, abuse, and other wrongdoing (related to Standard 1.A.7.d.).

- Conflict resolution, mediation, and collective bargaining agreements.

6.d.(1)(b) Harassment in the workplace might include unwelcome physical or verbal behavior such as offensive jokes, belittling comments, slurs, epithets, name calling, physical threats or assaults, ridicule or mockery, insults, offensive objects or pictures, or other interference with work performance that creates an intimidating or hostile work environment. Harassment can also include sexual harassment such as unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature.

6.d.(2) When there are new policies and written procedures, or changes to existing policies and procedures, the workforce might be notified via
departmental, team, or one-on-one meetings; posting notices in a common area of the building; email; the organization’s intranet system; or dissemination of a form requesting verification by individuals that they have completed a regular review of specified documents.

### Section 1.1. Workforce Development and Management

#### 7. Workforce development activities include:

- **a. Identification of competencies:**
  1. To support the organization in the accomplishment of its mission and goals.
  2. To meet the needs of the persons served.

- **b. Assessment of competencies.**

- **c. Identification of timeframes/frequencies related to the competency assessment process.**

- **d. Competency development, including the provision of resources.**

- **e. Performance appraisal.**

- **f. Education and training.**

**Intent Statements**

Refer to the Glossary for a definition of competency.

**Examples**

7.a. This may include competencies specific to a position, such as service delivery or clinical competencies, and competencies related to customer service, person-centered approaches to service delivery, communication with stakeholders, etc.

7.d. Competency development may occur through opportunities on the job and externally. Resources to develop competencies might include journal subscriptions, online access to learning opportunities and reference materials or journals, access to evidence-based practice databases and reviews, guest speakers, sponsoring educational events at the organization, inservice programs, journal clubs, collaborative resource or education efforts with other area providers of services, and financial support and/or time off to participate in special interest groups or to attend courses or conferences.

#### 8. The organization implements written procedures for performance appraisal that address:

- **a. The identified workforce.**
- **b. The criteria against which people are being appraised.**
- **c. Involvement of the person being appraised.**
- **d. Documentation requirements.**
- **e. Timeframes/frequencies related to the performance appraisal process.**
- **f. Measurable goals.**
- **g. Sources of input.**
- **h. Opportunities for development.**

**Intent Statements**

Organizations vary in their preferences and approaches to performance appraisal. For some, a traditional approach suits their needs, while others are evolving to a more fluid process that may look different for different members of the same workforce. To meet this standard the organization demonstrates implementation of a performance appraisal process that includes all of the elements of the standard as they apply to the groups that comprise its workforce (as documented in Standard 1. in this section). This allows the organization flexibility to determine what meets its needs relative to appraisal of employees, contractors, students, volunteers, etc.

**Examples**

8.b. Criteria might be included in a performance appraisal tool, job description, behavior attributes, expectations established through goal setting, employee handbook, etc.

8.d. This refers to documentation requirements of the performance appraisal process, such as whether a certain form is to be used, what elements are to be addressed, where documentation of performance appraisals is maintained, and at what intervals documentation is required.

8.f. A measurable goal describes an expected outcome, result, or output, which could be qualitative or quantitative, and has a timeline associated with reaching it. In addition, effective goals may be characterized as participative; reasonable; specific; challenging but attainable;
flexible; easily monitored for progress; and in alignment with an organization's mission, strategy, and goals. They may be individual, team-based, or project-based.

One approach to establishing goals is SMART goals—goals that are specific (simple, sensible, significant), measurable (meaningful, motivating), achievable (agreed, attainable), relevant (reasonable, realistic, and resourced, results based), and time bound (time based, time limited, time/cost limited, timely, time sensitive). For more information, visit www.mindtools.com/pages/article/smart-goals.htm.

8.g. Sources of input to the performance appraisal might include the person being appraised, supervisors, peers, persons served, families/support systems, external stakeholders, etc.

8.h. Opportunities for development may include supervisory/management training; clinical training to develop expertise in a particular practice, technique, or piece of equipment; training to move into another area of a continuum of services; and precepting students or responsibility for a student internship program.

Ident Statements
This standard relates to the organization's performance measurement and management; i.e., the collection, analysis, and use of data in areas such as finance, risk management, human resources, health and safety, service delivery, etc. Whether or not performance targets are met in these areas may reflect the adequacy of the workforce to meet the needs of the organization and the persons served.

No ratios are established by CARF for the number of persons served to the number of personnel. During a survey, the organization is able to articulate its strategy to determine what workforce is necessary to meet ongoing needs and to minimize the impact of absences and vacancies in its workforce.

Examples
9.a. Indications that the workforce is not adequate to implement the plans of the persons served may include wait lists or delays for specific services the program indicates in its scope that it can provide, turning potential persons served away, lacking specific types of providers to fulfill individual plans, inconsistent assignment of individuals in the workforce, and persons served not accomplishing their goals or the expected outcomes established by the team.

10. As applicable, the organization demonstrates a process to address the provision of services by the workforce consistent with relevant:
   a. Regulatory requirements.
   b. Licensure requirements.
   c. Registration requirements.
   d. Certification requirements.
   e. Professional degrees.
   f. Training to maintain established competency levels.
   g. On-the-job training requirements.

Intent Statements
The organization is knowledgeable about and ensures that services are provided in accordance with external and internal requirements and education relevant to its workforce.

Examples
10.a. Regulatory requirements may specify a certain credential for a position, a number of hours of service delivery, a number of hours of inservice training, etc.

11. The organization's succession planning addresses, at a minimum:
   a. Its future workforce needs.
   b. Identification of key positions.
   c. Identification of the competencies required by key positions.
   d. Review of talent in the current workforce.
e. Identification of workforce readiness.
f. Gap analysis.
g. Strategic development.

Intent Statements
This standard relates to Standards 1.A.3.m. and 1.B.5. on succession planning.
An organization relies on its workforce to carry out its mission, provide programs and services, and meet organizational goals. Important to any size organization, succession planning helps an organization prepare to support program and service continuity when key individuals leave, either planned or unexpectedly.

11.b. Key positions include those requiring specialized skills or levels of experience and those that may be difficult to replace.

11.d. A review of talent involves assessment of the current workforce with the goal of identifying those who have the skills and knowledge or the potential along with the desire to be promoted to existing and new positions.

11.e. Identification of workforce readiness considers the skills and knowledge already present in members of the workforce who have been identified for promotion to existing or new positions and the skills and knowledge that may need development.

11.f. Once an organization has identified positions that may be vacated due to retirements, are difficult for which to recruit, or require extended training, etc., it assesses the current workforce to determine whether there are candidates with the skills, knowledge, and potential to fill those positions or whether it needs to recruit and/or train candidates for those positions. Gap analysis identifies disparities between what is needed in the workforce and what is available.

Additional Resources

- Society for Human Resource Management: www.shrm.org
- HR Business and Legal Resources: https://hr.blr.com
- Association for Talent Development: www.td.org
- O*Net Online: www.onetonline.org
- Office of Personnel Management: www.opm.gov

Job Bank Employer Resources (Government of Canada): www.jobbank.gc.ca/content_pieces-eng.do?cid=3264#HR_needs


Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Documented description of the composition of the workforce
- Written job descriptions
- Written procedures that address verification of backgrounds; credentials; fitness for duty, if required; timeframes; and actions to be taken in response to information received
- Workforce policies and written procedures
- Written procedures for performance appraisals
- Succession planning information
J. Technology

Description
Guided by leadership and a shared vision, CARF-accredited organizations are committed to exploring and, within their resources, acquiring and implementing technology systems and solutions that will support and enhance:

- Business processes and practices.
- Privacy and security of protected information.
- Service delivery.
- Performance management and improvement.
- Satisfaction of persons served, personnel, and other stakeholders.

1. To identify gaps and opportunities in the use of technology, leadership supports ongoing assessment of:
   a. The organization’s current use of technology and data, including:
      (1) Hardware.
      (2) Software.
      (3) Communication technologies.
      (4) Sensitive data.
      (5) Services purchased or contracted.
      (6) Assistive technology.
   b. Input on the organization’s use of technology from:
      (1) Persons served.
      (2) Personnel.
      (3) Other stakeholders.

Intent Statements
The leadership is knowledgeable about the organization’s technology systems and is actively involved in its technology planning, rather than it being considered the sole responsibility or purview of information and technology personnel.

Examples
Ongoing assessment of gaps and opportunities relies, in part, on consistent management of the organization’s existing technology and data assets. This includes tracking of the lifecycle of assets and, in advance of those timeframes, assessing the best course of action. For example:

- Cell phones used by personnel have an upgrade option at an appropriate interval. Ahead of that time, the organization considers any input it has received from personnel on the utility and performance of the phones and assessments whether it will upgrade the phones, whether it will change cell phone plans, whether it will continue with the same cell phone carrier, etc.

- Laptop computers used by personnel average a five-year life expectancy before needing replacement. The organization periodically assesses new models, accessories, software upgrades, and alternatives such as tablets and establishes a plan for laptop replacement.

- The organization has software maintenance contracts and cloud subscriptions that require regular renewal. Throughout the periods of those contracts, the organization is assessing whether the services are meeting its needs, whether resolution of issues has been adequate, costs of renewal, duration of the contracts, and whether it will renew or seek new options.

Other components of ongoing assessment might include:

- Patching and malware prevention, including regular assessment of the organization’s operating systems and application updates. Often updates are released to patch security vulnerabilities in the operating system or software. Anti-malware/anti-virus software should be updating regularly; typically updates are automatic and multiple times a day. It is also good practice to keep the firmware of network switches and routers up to date.

- Perimeter security, which includes firewall/intrusion prevention; documentation of rules regarding what resources are open externally and why; keeping firmware/operating systems up to date; making sure that updates for malicious prevention are occurring and working; and checking log files for indications of problems, errors, failures, and traffic that has been prevented. The organization might use free
online security testers to evaluate the security settings of its web servers.

- Data security, which includes patching and software updates and controlling input to prevent database server exploitation.

- Network diagrams, which include keeping up-to-date diagrams of local and wide area network infrastructure, including equipment information such as make/model and routing and network addressing. This may also include mapping of application interactions, data repository, and flow.

- Asset list, which includes tracking what assets (hardware/software/systems) are in use and retired. This helps an organization know what it has, what it needs to keep patched, what has been stolen or destroyed, what has warranties and when they expire, what needs to be insured, what needs to be replaced and when, etc.

- Risk assessment, which helps the organization think about what risks exist, what can be fixed easily or not, what is high risk and worth fixing, etc. Frequently revisiting risks and remediation helps ensure that risk assessment and remediation planning stay relevant.

Through close tracking the organization minimizes its risks related to technology and data assets, assets continue to effectively and efficiently serve the intended purpose, and it has ample opportunity to consider and plan for updates and upgrades.

1.a.(3) Communication technologies might include telecommunications systems, websites, and social media.

1.a.(4) Sensitive data might include confidential corporate information and personal data about persons served or personnel that are protected by data privacy laws.

1.a.(5) This might include services provided by vendors such as technology consulting; software development and support; desktop, network, or other hardware support; website maintenance; and cloud services.

1.a.(6) The organization's use of technology includes assistive technology that may be used by persons served and personnel to improve functional capabilities and independence. To support effective service delivery for the persons served, programs/services may address assistive technology in the individual plans of persons served, make a variety of assistive technology available to try, partner with suppliers or other assistive technology resources in the community, etc. Examples of assistive technology that may be utilized by persons served include screen reading software, adaptive telephones, augmentative communication devices, adaptive mouse devices for using computers, environmental controls, wander management equipment, and voice recognition software.

1.b.(1) The organization may seek input from persons served on the ease with which they can use the technology available or the technology they would like to see implemented in the future. For example:

- Searching the organization's website for locations, contact information, services available, hours of operation, or performance and outcomes information.

- A portal through which they could schedule, submit insurance information, pay bills, email a provider, or download records.

- Information and communication technologies that would allow persons served to consult specialists, receive services remotely, or submit data collected by the persons served to their providers; e.g., weight, blood pressure, or glucose levels.

- A voice response system that they can easily navigate to reach someone at the organization or to bypass information they are already familiar with.

1.b.(2) Personnel may provide input on technology they use to perform their job duties, such as:

- Electronic medical record systems.

- Mobile technology that can be used for communication, documentation, etc.

- Billing software and systems.

- Remote access to the organization's systems and resources.

- Intranet that provides access to policies and procedures, databases, reporting, etc.
1.b.(3) The organization may have requirements from external stakeholders such as funders who require electronic exchange of information about persons served or electronic claims submission.

2. The organization implements a technology and system plan that:
   a. Is based on:
      (1) Its current use of technology and data.
      (2) Identification of gaps and opportunities in the use of technology.
   b. Includes:
      (1) Goals.
      (2) Priorities.
      (3) Technology acquisition.
      (4) Technology maintenance.
      (5) Technology replacement.
      (6) Resources needed to accomplish the goals.
      (7) Timeframes.
   c. Supports:
      (1) The business processes of the organization.
      (2) Protection of sensitive data.
      (3) Efficient operations.
      (4) Effective service delivery.
      (5) Access to services.
      (6) Performance improvement.
   d. Aligns with the organization’s strategic plan.
   e. Is reviewed for relevance.
   f. Is updated as needed.

Intent Statements
The technology and system plan addresses the programs/services seeking accreditation. If the programs/services are part of a larger organization and not specifically addressed in its technology and system plan, the programs/services may establish a separate plan or generate a supplement to the organization’s plan that addresses the elements in this standard.

3. The organization implements policies and procedures in the following areas:
   a. Acceptable use.
   b. Backup/recovery.
   c. Business continuity/disaster recovery.
   d. Security, including:
      (1) Access management.
      (2) Audit capabilities.
      (3) Data export and transfer capabilities.
      (4) Decommissioning of physical hardware and data destruction.
      (5) Protection from malicious activity.
      (6) Remote access and support.
      (7) Updates, configuration management, and change control.

Examples
3.a. Acceptable use policies and procedures might address authorized use of organization-issued technology, such as computers, tablets, cell phones, and USB drives, and use of email, the internet, information systems, networks, etc., including what a user is and is not allowed to do with those resources, such as whether an organization-issued laptop may be taken off the premises, whether personnel can use the internet for personal purposes during breaks, and whether printing of personal documents is allowed. Policies and procedures may also address the use of personal devices and technology for business operations.

3.b. Backup/recovery refers to the process of backing up data and setting up systems that allow data recovery in case of data loss or corruption. Policies and procedures might address the type of backup used; e.g., on site (backing up data onto a local storage device, such as a tape drive or another server’s hard drive) or off site (backing up data to a remote location or a co-location facility, or using an online cloud backup service); regular monitoring and testing of backup and restore processes to verify they function as expected; data retention timeframes; the need for multiple copies of data; and distribution of data in backup and recovery planning. An
The organization will want to broadly consider its use of technology for both business processes and service delivery in establishing adequate procedures and what could be at risk should data be lost from systems such as payroll; billing; scheduling; medical records; or portable devices used for communication, documentation, or other transfer of data about persons served.

3.c. Business continuity/disaster recovery is a set of processes used to help an organization recover from a disaster and continue or resume routine business operations. Business continuity addresses the availability of essential business functions and processes during and after a disaster and may include the replacement of personnel, service availability issues, business impact analysis, and change management. Disaster recovery processes may include server and network restoration, copying backup data, and provisioning backup systems.

3.d.(1) Access management refers to identification and management of access to and use of technology and information resources, including authorization and de-authorization or deactivation, physical access, and electronic access. User authorization and de-authorization may address password settings; e.g., complexity, expiration, use of temporary passwords; what happens when someone begins or leaves employment; supervisor access to confidential records of their employees; etc.

3.d.(2) Audit capabilities refers to a record or audit log showing who has accessed a computer system and what operations the person has performed during a given period of time.

3.d.(3) Data export and transfer capabilities may include defining what data are proprietary and secure, how data may be exported or transferred (e.g., email, on a flash drive, etc.), and whether data can be transferred to personal devices and back to organization-owned equipment. For example, an organization may have a policy that electronic medical records are not to be transferred via email or accessed from/stored on personal devices.

3.d.(4) Decommissioning of physical hardware and data destruction refers to the removal of hardware from active status and how that hardware will be disposed of without risking access to data; e.g., what an organization does with hard drives and backup tapes that are no longer used.

3.d.(5) Protection from malicious activity addresses protection from malicious software such as worms, viruses, trojans, spyware, adware, rootkits, etc., that accesses protected data, deletes data, or adds software not approved by the organization or user. Protection may be accomplished by firewalls, spam filtering, and other systems designed to prevent abuse or unauthorized use of systems.

3.d.(6) Remote access is the ability to access a computer or network from a separate location; e.g., someone at a branch office, a telecommuter, and/or someone traveling who may need access to the organization’s network or resources. Procedures may address who can remotely access organization information and technology and for what purpose, what equipment can be used to perform the remote access (organization-owned devices vs. personal devices), whether access is temporary or ongoing or limited to specific days or hours, and how access is accomplished. Remote access can be set up using a local area network (LAN), wide area network (WAN), or a virtual private network (VPN) so that resources and systems can be accessed remotely.

3.d.(7) Configuration management tracks an organization’s hardware, software, and related information; e.g., software versions and updates installed on the organization’s computer systems, network addresses belonging to the hardware devices used, etc. Change control is a systematic approach to modifying software applications or systems, patch installation, or network upgrades. Change control reduces the risk when introducing new technology (hardware or software) or changes to existing technology (e.g., software changes, operating system updates, firmware updates) by ensuring that testing and analysis are performed to understand the impacts of the change and by having procedures defined for the deployment of changes to ensure an orderly transition.
Section 1.J. Technology

1.J. A test of the organization’s procedures for business continuity/disaster recovery:
   a. Is conducted at least annually.
   b. Is analyzed for:
      (1) Effectiveness.
      (2) Areas needing improvement.
      (3) Actions to address the improvements needed.
      (4) Implementation of the actions.
      (5) Whether the actions taken accomplished the intended results.
      (6) Necessary education and training of personnel.
   c. Is evidenced in writing, including the analysis.

Intent Statements
These tests are similar in nature to the tests of emergency procedures required in Standard 1.H.7. and are intended to assist in determining if the procedures function as expected to protect the organization’s technology and data assets and identifying any areas where performance improvement is needed.

1.J. The organization provides documented training to personnel:
   a. On cybersecurity.
   b. On the technology used in performance of their job duties.
   c. Including:
      (1) Initial training.
      (2) Ongoing training.

Examples
5.a. This training will help ensure that personnel are familiar with the organization’s information security procedures, understand what information is sensitive and vulnerable, and are trained on steps to take to protect data assets.
5.c.(2) Ongoing training may be provided when there is an installation of new technology or software updates that impact how technology is used by personnel or that provide new features or functionality.

Additional Resources
■ SysAdmin, Audit, Network, Security (SANS) Institute Information Security Policy Templates: www.sans.org/security-resources/policies

Standards for Service Delivery Using Information and Communication Technologies

Applicable Standards
If the organization uses information and communication technologies (ICT) to deliver services, Standards 1.J.6.–12. apply.

Description
Depending on the type of program, a variety of terminology may be used to describe the use of information and communication technologies to deliver services; e.g., telepractice, telehealth, tele-mental health, telerehabilitation, telespeech, etc.
Based on the individualized plan for the person served, the use of information and communication technologies allows providers to see, hear, and/or interact with persons served, family/support system members, and other providers in remote settings. The use of technology for strictly informational purposes, such as having a website that provides information about the programs and services available, is not considered providing services via the use of information and communication technologies.

The provision of services via information and communication technologies may:

- Include services such as assessment, monitoring, prevention, intervention, follow-up, supervision, education, consultation, and counseling.

- Involve a variety of professionals such as case managers/service coordinators, social workers, psychologists, speech-language pathologists, occupational therapists, physical therapists, physicians, nurses, rehabilitation engineers, assistive technologists, and teachers.

- Encompass settings such as:
  - Hospitals, clinics, professional offices, and other organization-based settings.
  - Schools, work sites, libraries, community centers, and other community settings.
  - Congregate living, individual homes, and other residential settings.

6. The organization implements written procedures:

   a. That address:

      (1) Consent of the person served.
      (2) Audio recording, video recording, and photographing the person served.
      (3) Decision making about when to use information and communication technologies versus face-to-face services.

   b. To confirm that all necessary technology and/or equipment is available and functions:

      (1) Prior to the start of service delivery.
      (2) As needed throughout services.
      (3) At the:

         (a) Originating site.
         (b) Remote site.

Intent Statements

6.a.(1) The organization’s procedures include obtaining written consent to participate in service delivery via information and communication technologies when applicable.

Examples

6.a.(3) Information and communication technologies may be used for remote monitoring of a person served. For example, the individual plan might include:

- Biometric monitoring of persons with chronic conditions, such as monitoring of weight, blood pressure, or heart rate, to allow assessment of stable health or the need for medical attention.

- Motion sensors in someone’s home that indicate how much/when a person is up and about, may be in need of help, or may have left the home without the supervision necessary to be safe.

- Case management visits via computer or other electronic device for routine communications.

- Interactive voice response, such as someone with diabetes or a heart condition who reports
symptoms telephonically by responding to prerecorded questions. Certain answers prompt an alert to be sent to a service provider who can follow up with the person as needed.

- Personal emergency response systems, such as a pendant or bracelet worn by a person served. When the button is pushed or when the device senses a fall an emergency alert is transmitted to a predetermined contact to respond.

6.b.(2) There may be a need to confirm availability and/or function during the course of services if new technology or equipment is being implemented, there have been problems with the technology or equipment in prior sessions, or someone new will be responsible for operating the equipment or technology.

Resources
- 6.a.(1) Telemedicine & Informed Consent: How Informed Are You?
  http://southwesttrc.org/blog/2017/telemedicine-informed-consent-how-informed-are-you

7. As appropriate, personnel who deliver services via information and communication technologies receive competency-based training on equipment:
   a. Features.
   b. Setup.
   c. Use.
   d. Maintenance.
   e. Safety considerations.
   f. Infection control.
   g. Troubleshooting.

Examples
7.f. Infection control addresses equipment used at the originating site and the remote site. For example:

- Equipment that touches any part of the body or is used to look into someone's eyes, ears, or mouth is properly sanitized between each use.
- The person served and family members in the home are instructed in proper handwashing technique; shielding coughs and sneezes; and the use, if necessary, of gloves or masks to minimize risks associated with sharing equipment.
- When the person served is using a computer at a school or library, the keyboard, mouse, and headset are cleaned appropriately before they are used.

8. As appropriate, instruction and training are provided:
   a. To:
      (1) Persons served.
      (2) Members of the family/support system.
      (3) Others.
   b. On equipment:
      (1) Features.
      (2) Setup.
      (3) Use.
      (4) Troubleshooting.

9. Service delivery includes:
   a. Personnel to provide assistance with accessing services provided by the organization.
   b. Based on identified need:
      (1) An appropriate facilitator at the site where the person served is located.
      (2) Modification to:
         (a) Treatment techniques/interventions.
         (b) Equipment.
(c) Materials.
(d) Environment of the remote site, including:
   (i) Accessibility.
   (ii) Privacy.
   (iii) Usability of equipment.

Examples
9.b.(1) Depending on the purpose of the session and the needs of the person served, professional personnel, support personnel, family members, or caregivers might function in the role of facilitator.

10. Prior to the start of each session:
   a. All participants in the session are identified, including those at the:
      (1) Originating site.
      (2) Remote site.
   b. The organization provides information that is relevant to the session.

Examples
10.b. Information may be shared on the credentials of the provider, structure and timing of services, recordkeeping, scheduling, contact between sessions, privacy and security, potential risks, confidentiality, billing, rights and responsibilities, etc.

11. The organization maintains equipment in accordance with manufacturers’ recommendations.

12. Emergency procedures address the unique aspects of service delivery via information and communication technologies, including:
   a. The provider becoming familiar with the emergency procedures of the remote site, if the procedures exist.
   b. Identification of local emergency resources, including phone numbers.

Examples
When the person served is located at an organization or a community setting, the provider becomes familiar with the procedures of that setting in the event there is an emergency involving the person served. In the absence of emergency procedures for the setting where the person served is located, or when the person served is at home, the provider has immediate access to emergency contact information for the person served and information on local emergency resources, including their phone numbers.

Additional Resources
- American Telemedicine Association: www.americantelemed.org
- VA Telehealth Services: www.telehealth.va.gov/real-time
- International Journal of Telerehabilitation: telerehab.pitt.edu/ojs/index.php/Telerehab
- Center for Connected Health Policy: http://cchpca.org

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- Technology and system plan
- Policies and procedures on technology use, backup/recovery, business continuity/disaster recovery, and security
K. Rights of Persons Served

Description
CARF-accredited organizations protect and promote the rights of all persons served. This commitment guides the delivery of services and ongoing interactions with the persons served.

1.K. 1. The organization implements policies promoting the following rights of the persons served:
   a. Confidentiality of information.
   b. Privacy.
   c. Freedom from:
      (1) Abuse.
      (2) Financial or other exploitation.
      (3) Retaliation.
      (4) Humiliation.
      (5) Neglect.
   d. Access to:
      (1) Information pertinent to the person served in sufficient time to facilitate the person’s decision making.
      (2) Their own records.
   e. Informed consent or refusal or expression of choice regarding:
      (1) Service delivery.
      (2) Release of information.
      (3) Concurrent services.
      (4) Composition of the service delivery team.
      (5) Involvement in research projects, if applicable.
   f. Access or referral to:
      (1) Legal entities for appropriate representation.
      (2) Self-help support services.
      (3) Advocacy support services.
   g. Adherence to research guidelines and ethics when persons served are involved, if applicable.
h. Investigation and resolution of alleged infringement of rights.
   i. Other legal rights.

Intent Statements
To demonstrate relevant service delivery and appropriate ongoing communication with the persons served, the organization implements a system of rights that nurtures and protects the dignity and respect of the persons served. All information is transmitted in a manner that is clear and understandable.

Examples
When consent is required, there is also discussion of informed refusal. A person served may refuse to sign a consent form, but with that refusal, the organization is committed to explaining the risks and adverse consequences of the refusal.
During the survey, the survey team will interview persons, observe activities, and look at some records for the issues surrounding rights.

1.K. 2. The rights of the persons served are:
   a. Communicated to the persons served:
      (1) In a way that is understandable.
      (2) Prior to the beginning of service delivery or at initiation of service delivery.
      (3) At least annually for persons served in a program longer than one year.
   b. Available at all times for:
      (1) Review.
      (2) Clarification.

Intent Statements
To ensure that the persons served have a clear understanding of their rights, the organization communicates and shares these rights in a manner that is understandable to the persons served.

Examples
Copies of resident rights should be provided to persons served at all levels of the program; this includes the independent living area of a continuing care retirement community. Organizations might consider resident handbooks, meetings, in-house television, flyers, or providing information to residents at an annual flu shot clinic as mechanisms to accomplish this.
This could include large print, translations into different languages, audio and video recordings, an orientation handbook, and one-on-one verbal communication.

1.K. 3. The organization:
   a. Implements a policy and written procedure by which persons served may formally complain to the organization that specify:
      (1) Its definition of a formal complaint.
      (2) That the action will not result in retaliation or barriers to services.
      (3) How efforts will be made to resolve the complaint.
      (4) Levels of review, which include availability of external review.
      (5) Timeframes that:
         (a) Are adequate for prompt consideration.
         (b) Result in timely decisions for the person served.
      (6) Procedures for written notification regarding the actions to be taken to address the complaint.
      (7) The rights of each party.
      (8) The responsibilities of each party.
      (9) The availability of advocates or other assistance.
   b. Makes complaint procedures and, if applicable, forms:
      (1) Readily available to the persons served.
      (2) Understandable to the persons served.
   c. Documents formal complaints received.

Intent Statements
The organization identifies clear protocols related to formal complaints, as defined by the organization.
Section 1.K. Rights of Persons Served

1.K. An analysis of all formal complaints:
   a. Is conducted at least annually.
   b. Is documented, including:
      (1) Whether formal complaints were received.
      (2) Trends.
      (3) Areas needing performance improvement.
      (4) Actions to address the improvements needed.
      (5) Implementation of the actions.
      (6) Whether the actions taken accomplished the intended results.

Intent Statements
An analysis of formal complaints can give the organization valuable information to facilitate change that results in better customer service and results for the persons served.

Examples
As complaints may, in some organizations, be part of risk management, this information may be documented in a variety of reports and used for a variety of different purposes. Trends or analysis reports may be shared with boards, leadership, personnel, etc.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Policies promoting the rights of the persons served
- Policy and procedures for formal complaints
- Definition of a formal complaint
- Information regarding staff training on rights of persons served, informed consent, complaint/grievance procedures, etc.
- Handbook for persons served, orientation materials, updated information regarding rights
- Records of the persons served showing informed consent
- Conflict resolution information
- Grievance and appeal process
- Documentation of formal complaints received
- Documentation showing review and analysis of formal complaints at least annually
- Action plan or changes made to improve performance and to reduce complaints
- External and internal investigation reports and related corrective action plans
- Documentation that rights of persons served are reviewed at least annually with the persons served, if applicable.
L. Accessibility

Description
CARF-accredited organizations promote accessibility and the removal of barriers for the persons
served and other stakeholders.

1. The organization’s leadership:
   a. Assesses the accessibility needs of the:
      (1) Persons served.
      (2) Personnel.
      (3) Other stakeholders.
   b. Implements an ongoing process for identification of barriers in the following areas:
      (1) Architecture.
      (2) Environment.
      (3) Attitudes.
      (4) Finances.
      (5) Employment.
      (6) Communication.
      (7) Technology.
      (8) Transportation.
      (9) Community integration, when appropriate.
      (10) Any other barrier identified by the:
            (a) Persons served.
            (b) Personnel.
            (c) Other stakeholders.

Intent Statements
The leadership has a working knowledge of what should be done to promote accessibility and remove barriers. Organizations address accessibility issues in order to:

■ Enhance the quality of life for those served in their programs and services.
■ Implement nondiscriminatory employment practices.
■ Meet legal and regulatory requirements.
■ Meet the expectations of stakeholders in the area of accessibility.

Examples
Examples of barriers include the following:

■ Architecture: width of doors, steps without ramps, narrow doorways, multilevel buildings without elevators, historic buildings, or carpet that aggravates allergies.
■ Environment: poor signage; low lighting; a noisy environment; or lack of understanding regarding how to use emergency response systems, such as pull cords, pendants, and other similar systems.
■ Attitude: assumptions based on age, ethnic background, or socioeconomic status.
■ Finances: limited payment for needed services, lack of additional resources in a community to offset additional needs, financial fees.
■ Employment: care attendants are mainly from other countries and English is a second language, shortages in critical areas (e.g., nursing, RNs, CNAs, PSWs), or the location of the organization makes it difficult for employees who use public transportation.
■ Communication: lack of translation of materials into formats that are appropriate for stakeholders to understand, insufficient training for personnel on diversity issues, lack of assistive technology to augment communication, lack of hearing amplification equipment in community settings that the persons served use.

In addition to barriers resulting from design and attitudinal and competency barriers, many people experience barriers of inaccessible diagnostic, therapeutic, procedural, rehabilitation, and exercise equipment, such as examination and treatment tables and chairs, weight scales, x-ray equipment, glucometers, blood pressure cuffs, and treadmills and other exercise equipment.
Transportation: limited accessible public transportation, increasing number of persons served with no transportation available to them, limited vehicles that deal with various physical impairments (height, weight, mobility), price of gasoline.

Community integration: lack of opportunities to engage with community organizations such as those pertaining to religious, educational, social, and volunteer issues.

1.b.(9) Barriers to community integration may include any barrier that would keep the persons served from returning to full participation in their community of choice. For example, participation in sports may be limited by the lack of a lift at the public swimming pool for access by persons served with limited mobility or the lack of scheduling availability of the local gym for an adaptive sports program, or accommodations may be needed for the persons served to return to previous volunteer activities with the community food bank.

Resources

Information on the ADA is provided by the U.S. Department of Justice: www.ada.gov.

An Overview of Canada’s Accessibility Laws: www.essentialaccessibility.com/blog/canadian-accessibility-laws/.

1.b.(6) Resources on accessibility and health literacy include:

- Shirley Ryan AbilityLab Health Literacy: www.sralab.org/lifecenter/resources/health-literacy-using-plain-language-health-communications
- U.S. Department of Health and Human Services Agency for Healthcare Research and Quality: www.ahrq.gov/topics/health-literacy.html
- Center for Plain Language: www.centerforplainlanguage.org
- World Wide Web Consortium Web Accessibility Initiative: www.w3.org/WAI
- ABC Life Literacy Canada: www.literacy.ca/?q=literacy/clearwriting
- LiteracyBC: www.literacybc.ca/PLRC/ResourceCentre.html
- Language Portal of Canada: www.noslangues-ourlanguages.gc.ca
- Canadian Public Health Association Plain Language Service: www.cpha.ca/plain-language-service

1.L. 2. The organization implements an accessibility plan that:

   a. Includes, for all identified barriers:
      (1) Actions to be taken.
      (2) Timelines.
   b. Is reviewed at least annually for relevance, including:
      (1) Progress made in the removal of identified barriers.
      (2) Areas needing improvement.
   c. Is updated as needed.

Intent Statements

There may be barriers identified that the organization does not have the authority or resources to remove; effective accommodations may be the appropriate action to be taken in those circumstances.

Examples

Examples of conformance may be found in minutes of meetings where analysis, action planning, and goals are established; conversations with stakeholders; focus groups and council meetings; community events; surveys; etc.

At a minimum, the planning addresses:

- The barriers that limit access to programs and services.
- A detailed outline of the methods to be used in removing barriers and making programs accessible.
- A schedule for taking necessary steps to decrease or remove the identified barriers. If the time period for achieving conformance is to be longer than one year, the plan should identify the interim steps to be taken to achieve program access.

Barrier removal that is not readily achievable at first might be achievable later when the organization has more resources available. An organization must continually monitor its
accessibility, as well as its financial and other resources, and remove barriers as new measures become readily achievable. The organization’s plan may have options for the use of and referral to other services that may be more accessible.

In order to develop an accessibility plan, an organization first identifies barriers. When identifying potential barriers to services, the organization looks at barriers within the organization itself and in the community. In the U.S., an ADA checklist may be helpful in conducting this evaluation. For organizations in Canada, accessibility issues are addressed by federal and provincial acts on accessibility, human rights, and employment.

3. Requests for reasonable accommodations are:
   a. Identified.
   b. Reviewed.
   c. Decided upon.
   d. Documented.

Intent Statements
The organization evaluates and carefully considers the merits of all requests for accommodation to determine whether any remedial actions are appropriate.

Please see the Glossary for a definition of reasonable accommodations.

Examples
According to certain regulatory requirements, organizations may need to have procedures and a point of contact in place regarding requests for reasonable accommodations. Information regarding how to request reasonable accommodations may be in employee handbooks, or they may be identified in public information postings related to employee rights throughout the organization.

A request for a reasonable accommodation does not automatically require that the organization meet the request. There should be an investigation of the request. How is the organization alerted to the need for the reasonable accommodation? What is the review process? Who is identified as responsible for approving or denying the accommodation request? What are the decision-making criteria?

When an accommodation cannot be made, the organization demonstrates a referral system that assists the persons served to use other resources that are accessible.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written accessibility plan
- Identification of accessibility barriers
- Review of accessibility plan at least annually
- Requests for reasonable accommodations
- Documentation regarding reasonable accommodations that have been provided
- Meeting minutes
- Information regarding leadership advocacy activities
- If virtual access to services is provided, policies/procedures to ensure accessibility and accommodations
Review Results

M. Performance Measurement and Management

Description
CARF-accredited organizations demonstrate a culture of accountability by developing and implementing performance measurement and management plans that produce information an organization can act on to improve results for the persons served, other stakeholders, and the organization itself.

The foundation for successful performance measurement and management includes:
- Leadership accountability and support.
- Mission-driven measurement.
- A focus on results achieved for the persons served.
- Meaningful engagement of stakeholders.
- An understanding of extenuating and influencing factors that may impact performance.
- A workforce that is knowledgeable about and engaged in performance measurement and management.
- An investment in resources to implement performance measurement and management.
- Measurement and management of business functions to sustain and enhance the organization.

NOTE: Please refer to the Glossary for definitions of the following terms used throughout this section: person served, family/support system, stakeholders, performance indicator, performance target, effectiveness, efficiency, service access, validity, reliability, and value.

1.M. 1. The leadership demonstrates accountability for performance measurement and management in:
   a. Service delivery.
   b. Business functions.

Intent Statements
To survive and thrive in today’s environment, health and human services providers must produce value. Through service delivery and business practices that are ethical, state of the art, and durable, organizations strive to meet the needs of their stakeholders, sustain their programs/services, and support growth. Leadership accountability is demonstrated through engagement in and support of the organization’s performance measurement and management activities and effective utilization of the information produced to improve the quality of programs/services; make decisions; uphold the organization’s mission; and objectively demonstrate value to persons served and their families/support systems, other stakeholders, and the organization itself.

Examples
The leadership may review established objectives, performance indicators, and measures to confirm that the information being gathered can be used to answer questions from a variety of stakeholders, guide the organization, and identify areas for improvement.

There may be leadership representation on quality committees, performance improvement teams, and in meetings with stakeholders to gather input and suggestions about the organization’s performance management activities and plans.

The leadership may hold forums to seek input and insight into topics that could be incorporated into and addressed in the performance measurement and management plan.
There may be an ongoing, open exchange with internal stakeholders via an intranet to ensure that items measured are addressing areas that are critical to the organization and meeting stakeholder needs.

There may be a variety of mechanisms used to exchange information with stakeholders, such as town hall meetings; on-line surveys; members of the leadership team meeting with small groups of persons served, personnel, or other stakeholders; etc.

The leadership supports and may participate with personnel in training on assessment tools being used and methods to ensure data integrity.

The governance board may establish a quality committee that reviews performance reports on a regular basis.

The organization identifies gaps and opportunities in preparation for the development or review of a performance measurement and management plan, including consideration of:

2.a. Input from:
   (1) Persons served.
   (2) Personnel.
   (3) Other stakeholders.

2.b. The characteristics of the persons served.

2.c. Expected results.

2.d. Extenuating and influencing factors that may impact results.

2.e. The comparative data available.


2.g. Technology to support implementation of the performance measurement and management plan.

Intent Statements

An analysis of gaps and opportunities provides an organization with essential information in preparation for developing a performance measurement and management plan for the first time or reviewing it for continued relevance and/or necessary changes. Input from persons served, personnel, and other stakeholders about what they want to know about the organization and its programs/services guides the selection of objectives, performance indicators, and measures and positions the organization to later share performance information that meets stakeholder needs. A meaningful performance measurement and management plan elevates an organization's accountability for and knowledge and understanding of the results of its service delivery and business practices.

Through the analysis of gaps and opportunities it may be determined that changes are indicated not only in the performance measurement and management plan but also in areas such as strategic planning, person-centered practices, advocacy for persons served, corporate responsibilities, etc.

Examples

2.b. Characteristics include a wide variety of data that reflect relevant information about the persons served. In the context of performance management this information can be used to analyze performance relative to specific groups of persons served who share similar characteristics. Similarly, there are characteristics or conditions in the environment that may be shared by a group of persons or a population served. These are referred to as social determinants of health (SDOH)—conditions in the environments in which people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH such as income and social status, employment and working conditions, education and literacy, physical environments, social supports and coping skills, health behaviors, and access to health services may also impact the results that can be achieved for the persons served by a program. For example, in an area where the unemployment rate is low, job placement for persons served may be more challenging or return-to-work rates may be lower; in an area where there is limited public transportation, persons served may have difficulty attending the program or following through with transition/discharge recommendations; in an area where there is limited affordable housing, the discharge or placement options for persons served may be limited. All of these SDOH may impact the
results the program can achieve for the persons served and may also be considered in establishing the program’s performance targets.

2.d. Examples of extenuating or influencing factors that could impact performance include a change in leadership, relocation of an organization or program, reductions in budget, personnel shortages, new regulations, changes in the geographic area where services are offered such as a housing shortage, financial challenges in the community such as high unemployment, poor public transportation, a natural disaster such as a hurricane or earthquake, and individuals entering the programs/services with more co-morbidities or co-occurring conditions.

1.M. 3. The organization implements a performance measurement and management plan that:
   a. Addresses:
      (1) Collection of relevant data on the characteristics of the persons served.
      (2) For each program/service seeking accreditation, identification of measures for service delivery objectives, including, at a minimum:
         (a) Results achieved for the persons served (effectiveness).
         (b) Experience of services received and other feedback from the persons served.
         (c) Experience of services and other feedback from other stakeholders.
         (d) Resources used to achieve results for the persons served (efficiency).
         (e) Service access.
      (3) The collection of data about the persons served at:
         (a) The beginning of services.
         (b) Appropriate intervals during services.
         (c) The end of services.
         (d) Point(s) in time following services.
      (4) Identification of priority measures determined by the organization for business function objectives.
      (5) The extent to which the data collected measure what they are intended to measure (validity).
      (6) The process for obtaining data:
         (a) In a consistent manner (reliability).
         (b) That will be complete.
         (c) That will be accurate.
      (7) Extenuating and influencing factors that may impact results.
      (8) Timeframes for the:
         (a) Analysis of data.
         (b) Communication of results.
      (9) How:
         (a) Data are collected.
         (b) Data are analyzed.
         (c) Performance improvement plans are developed.
         (d) Performance improvement plans are implemented.
         (e) Performance information is communicated.
   b. Is reviewed at least annually for relevance.
   c. Is updated as needed.

Intent Statements

3.a.(1) Characteristics include a wide variety of data that reflect relevant information about the persons served. As data are collected and aggregated at the level of each program/service seeking accreditation, the identification and analysis of any significant performance differences of the program/service in serving relevant groups ties into later being able to target specific program improvements.

3.a.(4) Measurement of business functions is addressed in a number of related standards throughout Section 1, including, but not limited to, 1.F.5. on the analysis of financial performance,
1.H.7. on the testing of emergency procedures, 1.H.11. on the analysis of critical incidents, 1.J.4. on the testing of business continuity/disaster recovery procedures, and 1.K.4. on the analysis of formal complaints. The organization might identify these and/or other priority areas for business function measurement.

3.a.(5)–(6) It is not required that the organization subscribe to a proprietary data vendor in order to achieve data integrity.

Examples

3.a.(3)(d) Data may be collected at point(s) in time following services through use of a survey that is mailed or emailed to persons served, phone calls to persons served, or in-person at a follow-up visit to the program/service or to another provider to which the person was referred at transition/discharge.

When the reason for transition/discharge from the program/service is that the person served has died, or this is discovered after the person has left the program/service, follow-up efforts may focus on the family/support system; e.g., whether they were satisfied with the services the person served received, whether they received the support they desired from the program, resources the program can offer to support the family/support system in their grieving process, etc.

3.a.(4) An organization may identify priority business areas based on input from stakeholders or circumstances such as implementation of new program/service, opening of a new location, turnover in key leadership or management positions, or recent history of a natural disaster.

3.a.(5) The organization chooses indicators, measures, and data elements that measure what it intends to measure.

The analysis of gaps and opportunities addressed in Standard 1.M.2. may identify changes in measures for service delivery objectives that may need to occur because of changes in the environment, legislative or regulatory changes, societal or financial changes, or development or revision of programs/services.

3.a.(5)–(6) There are a variety of ways an organization can demonstrate that it addresses the integrity of the data it uses for performance measurement, management, and improvement and management decision making. These approaches can range from simple to sophisticated.

3.a.(6)(a) The organization takes steps to ensure that data are collected consistently in a way that could be reproduced at another time or by other data gatherers. For example:

- New and existing personnel are trained on recording each data element they are responsible for collecting, and measures or codes are explained and periodically reviewed.

- Inter-rater reliability assessments can be conducted in which different personnel record measures for the same persons served and data are compared statistically to assess whether different personnel arrive at the same ratings for a given individual.

- A potential training opportunity might be for a multi-site organization to have personnel from one location conduct screenings/assessments at other locations to help to increase the reliability of the screening/assessment process.

3.a.(6)(b) The organization takes steps to ensure that the data used for decision making are as complete as possible, no accredited programs are omitted from the information and performance improvement effort, no groups of persons served are omitted from the data gathering or analysis, no data elements or indicators are systematically missing, and any database is checked for completeness of records before final analyses are run and decisions made. For example:

- The quality council and data managers collaborate on designing an information system regarding the persons served that includes necessary data elements for all programs of the organization. They decide to design an organizationwide system, but identify each record with the particular program in which the person participates so analysis can be done separately for all the programs to be surveyed.

- Personnel training for data-recording activities includes attention to the importance of recording each data field for every person served.

- Complete information on the characteristics of the persons served, for example, is critical
to being able to analyze performance related to specific groups or populations served by a program.

- The data manager routinely cross checks the number of records of persons served in the database with the operations officer’s report of the number of persons served during a reporting period to ensure that data are available on all persons served before analysis is conducted and reports are generated. Missing records are located and entered into the database before analysis is conducted.

3.a.(6)(c) The organization takes steps to ensure that data are recorded properly and that errors are caught and corrected. For example:
- Spot checks of the records of the persons served are made to ensure that data abstracted from the record are correctly entered into the database.
- The data manager routinely reviews the distribution of values in test data runs and asks the direct care personnel to double check the accuracy of cases that seem to be outside of expectations in terms of maximum or minimum values. (For example, did someone really stay in the program 205 days or was it 20 days?)

1.M. 4. To measure its results achieved for the persons served (effectiveness), each program/service seeking accreditation documents:

a. An objective(s).

b. A performance indicator(s), including:
   (1) To whom the indicator(s) will be applied.
   (2) The person(s)/position(s) responsible for collecting the data.
   (3) The source(s) from which data will be collected.
   (4) Identification of relevant time-frames for collection of data.
   (5) A performance target that is based on the organization’s performance history or established by the organization or a stakeholder or is based on an industry benchmark.

Intent Statements

4.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples

4.b.(4) Measuring change over time is inherent in the measurement of results achieved for the persons served. Data collected at the beginning of services, at specific intervals during services, at the end of services, and/or at a point(s) in time following services allow the program/service to measure change over time. Examples of effectiveness measures include:
- Increased or continued independence in instrumental activities of daily living (IADL) and activities of daily living (ADL).
- Increase in community/social engagement.
Decrease in social isolation.
- Reduction in caregiver burden.
- Reduction in falls.
- Sense of safety and security.
- Reduction in emergency room visits or rehospitalizations.
- Wound/skin care.
- Management of chronic diseases.
- Health promotion and wellness.
- Quality of life.
- Positive health behaviors.
- Decrease in depression.
- Reduction in use of restraints, both physical and chemical.
- Use of psychotropic medications.
- Medication management.
- Engagement in activity programming.

1.M.5. To measure experience of services received and other feedback from the persons served, each program/service seeking accreditation documents:
  a. An objective(s).
  b. A performance indicator(s), including:
     1) To whom the indicator(s) will be applied.
     2) The person(s)/position(s) responsible for collecting the data.
     3) The source(s) from which data will be collected.
     4) Identification of relevant timeframes for collection of data.
     5) A performance target that is based on the organization’s performance history or established by the organization or a stakeholder or is based on an industry benchmark.

Intent Statements

5.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples

The perception of the persons served regarding their experience with the program/service provides valuable feedback on how well the program/service is meeting or met their expectations in areas such as service responsiveness, respect, informed choice, participation, and overall value. For example:

- Was the person served treated with dignity and respect?
- Did the program focus on the needs of the person served and the family?
- Were grievances or concerns addressed?
- Overall feelings of satisfaction.
- Use of informed choices about modes of treatment, medications, etc.
- Use of informed choices about services/supports.
- Satisfaction with physical facilities, fees, access, and results achieved.
I would move into this community if I were to do it again.
I am satisfied with the quality of food that is available.
The transportation provided/arranged is convenient.

The tools used to measure the experience of services received and other feedback are appropriate for the population served in terms of age, developmental level, language, and culture.

1.M. 6. To measure experience of services and other feedback from other stakeholders, each program/service seeking accreditation documents:
   a. An objective(s).
   b. A performance indicator(s), including:
      (1) To whom the indicator(s) will be applied.
      (2) The person(s)/position(s) responsible for collecting the data.
      (3) The source(s) from which data will be collected.
      (4) Identification of relevant timeframes for collection of data.
      (5) A performance target that is based on the organization’s performance history or established by the organization or a stakeholder or is based on an industry benchmark.

Intent Statements
6.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target.

It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples
The perception of stakeholders regarding their experience with the program/service provides valuable feedback on how well the program/service is meeting or met their expectations. For example:
- The information I received from the program met my needs.
- The information I received from the program was useful in my decision making.
- I received information from the program in a timeframe that met my needs.
- I am satisfied with the opportunities available to interact with the team serving my family member.
- I am satisfied with the services/care my family member received from the program.
- I would recommend this program to others.
- I would refer again to this program.
- I am satisfied with the timeframe for admission to services for persons referred.
- I am satisfied with the communication mechanisms to coordinate care for persons served.
7. To measure the resources used to achieve results for the persons served (efficiency), each program/service seeking accreditation documents:
   a. An objective(s).
   b. A performance indicator(s), including:
      1) To whom or what the indicator(s) will be applied.
      2) The person(s)/position(s) responsible for collecting the data.
      3) The source(s) from which data will be collected.
      4) Identification of relevant time-frames for collection of data.
      5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark.

Intent Statements

7.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples

7.b Efficiency measures address the relationship between resources used and results achieved. Resources may include time, money, personnel, etc. For example:
   - Service delivery cost per service unit.
   - Staffing ratios and consistency in staff.
   - Utilization of staffing agency for coverage.
   - Time to fulfill maintenance requests.
   - Direct service hours of clinical staff or other personnel.

8. To measure service access, each program/service seeking accreditation documents:
   a. An objective(s).
   b. A performance indicator(s), including:
      1) To whom or what the indicator(s) will be applied.
      2) The person(s)/position(s) responsible for collecting the data.
      3) The source(s) from which data will be collected.
      4) Identification of relevant time-frames for collection of data.
      5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark.

Intent Statements

8.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature
and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

**Examples**

8.b. Service access addresses the organization’s capacity to provide services to those who desire or are in need of receiving services. For example:

- Convenience of service hours and locations.
- Waiting time for routine or emergency care.
- Time taken to set a first or subsequent appointment.
- Waiting list information on persons found ineligible for services.
- Telephone response time.
- The success of formal referral mechanisms.
- Impact of funding or resources available.
- Response times to resident calls for assistance.
- Time to fill a vacant apartment/unit.
- Access to transportation.

**1.M. 9.** To measure its business function, the organization documents:

- Objectives in priority areas determined by the organization.
- For each objective, a performance indicator(s), including:
  1. To what the indicator(s) will be applied.
  2. The person(s)/position(s) responsible for collecting the data.
  3. The source(s) from which data will be collected.
  4. Identification of relevant time-frames for collection of data.
  5. A performance target that is based on the organization’s performance history or established by the organization or a stakeholder or that is based on an industry benchmark.

**Intent Statements**

Measurement of business functions is addressed in a number of related standards throughout Section 1, including, but not limited to, 1.F.5. on the analysis of financial performance, 1.H.7. on the testing of emergency procedures, 1.H.11. on the analysis of critical incidents, 1.J.4. on the testing of business continuity/disaster recovery procedures, and 1.K.4. on the analysis of formal complaints. The organization might identify these and/or other priority areas for business function measurement.

9.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In
this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples

In the area of financial planning and management, the organization might identify indicators related to expenses, revenues, or other budgetary information; financial reliance on related entities; its review of billing against records of the persons served; collections on bills for services rendered; or denial rates for billed services.

In the area of accessibility status reports, the organization might identify an indicator related to implementation of its accessibility plan and progress made in the removal of barriers.

In the area of risk management, an indicator might be identified related to the organization's actions to reduce risks, success of a fall prevention program, remediation plans addressing financial stability, number of complaints received, or medication errors.

Human resource indicators might be identified for recruitment, retention, or personnel turnover or the provision of training to personnel.

Health and safety indicators might relate to the analysis of unannounced tests of emergency procedures, critical incidents, infection control, or timeliness of response to maintenance requests for repairs found during external or internal inspections.

Examples

Personnel may have a variety of roles and responsibilities in implementing the organization's performance measurement and management plan, including:

- Completing assessment tools from which data are gathered.
- Collecting data.
- Analyzing data.
- Participating on performance improvement teams or committees.
- Identifying or revising objectives, performance indicators, and performance targets.
- Establishing methods to communicate performance information to persons served, personnel, and other stakeholders.
- Training and/or mentoring peers on the importance of using performance information.
- Working in a quality department that has overall responsibility for performance management and quality.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Performance measurement and management plan
- Business reports and plans; e.g., management reports, strategic plan, budgets and financial reports, accessibility plan, technology plan, risk management plan, health and safety reports
- Demographic information about persons served
- Data collected and collection process
- Follow-up information
- Priority measures for business function objectives, performance indicators, and performance targets

1.M. **Personnel are provided with documented education and training in accordance with their roles and responsibilities for performance measurement and management.**
For each program/service seeking accreditation, identification of measures for service delivery objectives, performance indicators, and performance targets

Documented personnel education and training that reflect roles and responsibilities for performance measurement and management
N. Performance Improvement

Description
CARF-accredited organizations demonstrate a culture of performance improvement through their commitment to proactive and ongoing review, analysis, reflection on their results in both service delivery and business functions, and transparency. The results of performance analysis are used to identify and implement data-driven actions to improve the quality of programs and services and to inform decision making. Performance information that is accurate and understandable to the target audience is shared with persons served, personnel, and other stakeholders in accordance with their interests and needs.

1.N. 1. The analysis of service delivery performance:
   a. Is documented.
   b. Is completed at least annually and in accordance with the timeframes outlined in the performance measurement and management plan.
   c. Addresses service delivery indicators for each program/service seeking accreditation, including, at a minimum:
      (1) Results achieved for the persons served (effectiveness).
      (2) Experience of services received and other feedback from the persons served.
      (3) Experience of services and other feedback from other stakeholders.
      (4) Resources used to achieve results for the persons served (efficiency).
      (5) Service access.
   d. Incorporates the:
      (1) Characteristics of the persons served.
      (2) Impact of extenuating or influencing factors.
   e. Includes:
      (1) Comparative analysis.
      (2) Identification of trends.
      (3) Identification of causes.
   f. Is used to:
      (1) Identify areas needing performance improvement.
      (2) Develop an action plan(s) to address the improvements needed.
      (3) Implement the action plan(s).
      (4) Determine whether the actions taken accomplished the intended results.

Intent Statements
Through implementation of the standards in Section 1.M., the organization establishes its framework for performance measurement and management, including the identification of objectives, performance indicators, and performance targets related to service delivery. Analyzing each performance indicator in relation to its target, including consideration of the characteristics of the persons served and extenuating or influencing factors that may impact performance, provides the organization with information on areas meeting or exceeding targets and areas in need of improvement. An action plan for improvement can then be developed in accordance with the organization’s priorities, resources, and other considerations.
The analysis of performance at least annually provides information on value and satisfaction to the persons served and other stakeholders. The performance analysis reviews data aggregated at a program/service level for each program/service seeking accreditation in order that the action plan(s) can target improvements at the individual program/service level.

1.N. 2. The analysis of business function performance:
   a. Is documented.
   b. Is completed at least annually and in accordance with the timeframes outlined in the performance measurement and management plan.
   c. Addresses priority business function indicators determined by the organization.
   d. Incorporates the:
      (1) Characteristics of the persons served, if applicable.
      (2) Impact of extenuating or influencing factors.
   e. Includes:
      (1) Comparative analysis.
      (2) Identification of trends.
      (3) Identification of causes.
   f. Is used to:
      (1) Identify areas needing performance improvement.
      (2) Develop an action plan(s) to address the improvements needed.
      (3) Implement the action plan(s).
      (4) Determine whether the actions taken accomplished the intended results.

Intent Statements
Through implementation of the standards in Section 1.M., the organization establishes its framework for performance measurement and management, including the identification of objectives, performance indicators, and performance targets related to business functions. Analyzing each performance indicator in relation to its target, including consideration of extenuating or influencing factors that may impact performance and, if applicable, the characteristics of the persons served, provides the organization with information on areas meeting or exceeding targets and areas in need of improvement. An action plan for improvement can then be developed in accordance with the organization’s priorities, resources, and other considerations.

The analysis of performance at least annually provides information to aid in the strategic positioning of the organization and builds a stronger business foundation and engaged workforce.

1.N. 3. The results of performance analysis are used to:
   a. Improve the quality of programs and services.
   b. Facilitate organizational decision making regarding:
      (1) Service delivery.
      (2) Business functions.
   c. Guide changes to the performance measurement and management plan.

Intent Statements
CARF-accredited organizations use a fact-based decision-making process to identify and respond to organizational and stakeholder needs. Although not every performance indicator that is measured and analyzed may be acted on, the information gleaned from the analysis allows for a fact-based approach to decision making, planning, and performance improvement.

Examples
The organization demonstrates:
- Knowledge of the operational status of the organization, the business strategies it employs to be successful, and how performance improvement is utilized at all levels of the organization.
- How it makes decisions to expand, remodel, open new sites, develop new services, modify a treatment or service approach, or change staffing patterns.
How it responds to or prepares for changes in regulations, reimbursement, or corporate structure.

Methods for reaching these decisions, which may include reviews of information, performance management reports, budgets, strategic plans, input forums, gap analyses, and satisfaction surveys.

1.N. 4. In accordance with the performance measurement and management plan, the organization communicates accurate performance information:
   a. To:
      (1) Persons served.
      (2) Personnel.
      (3) Other stakeholders.
   b. According to the needs of the specific group, including:
      (1) Content.
      (2) Format.
      (3) Timing.

Intent Statements
Sharing performance information with internal and external stakeholders is a vital aspect of continuously improving the programs/services of the organization. CARF-accredited organizations realize the importance of transparency and sharing performance information that is relevant and accurate with the persons served, personnel, and other stakeholders. Stakeholder input guides the content, format, and timing of the information shared so that it meets the needs of stakeholders both internal and external to the organization.

Examples
The content of the information shared is tailored to the needs of the audience and what the specific stakeholder group would like to know about the programs/services. The information is presented in a format and language that is understandable to those with whom it is shared. Format may vary for different stakeholder groups. For example, performance information could be communicated through:
   ■ Annual reports.
   ■ Press releases.
   ■ Newsletters.
   ■ Narrative reports.
   ■ Bulleted summaries or fact sheets.
   ■ Pie charts.
   ■ Bar graphs.
   ■ Balanced scorecards.

Information could be mailed, emailed, posted on the organization’s website, displayed in a reception area, audio or video recorded, or presented in person. To further meet the needs of stakeholders, information may be provided in a large font size, using more graphics than text, in various languages, in Braille, or utilizing captioning or interpreters.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

   ■ Documented analysis of service delivery performance at least annually and in accordance with the timeframes outlined in the performance measurement and management plan
   ■ Documented analysis of priority business function performance at least annually and in accordance with the timeframes outlined in the performance measurement and management plan
   ■ Action plans to address improvements needed
   ■ Management reports or meeting minutes
   ■ Follow-up information
   ■ Dashboards, scorecards, or other performance information provided to stakeholders
SECTION 2

Care Process for the Persons Served

A. Program/Service Structure

2.A. 1. Each program/service:
   a. Documents the following parameters regarding its scope of services:
      (1) Population(s) served.
      (2) Settings.
      (3) Hours of services.
      (4) Days of services.
      (5) Frequency of services.
      (6) Payers and funding sources.
      (7) Fees.
      (8) Referral sources.
      (9) The specific services offered, including whether the services are provided directly, by contract, or by referral.
   b. Shares relevant information about the scope of services with:
      (1) The persons served.
      (2) Families/support systems, in accordance with the choices of the persons served.
      (3) Referral sources.
      (4) Payers and funding sources.
      (5) Other relevant stakeholders.
      (6) The general public.
   c. Reviews the scope of services at least annually and updates it as necessary.

Examples

The scope may be defined in written entry criteria, a written program description, an outcomes system description, or a policy and procedure. An organization advertises that it has a certain program. It has the appropriate equipment and space, and personnel who possess the competencies to meet the needs of persons served. An organization is sponsored by a religious organization, but takes persons served of all faiths. It provides access to spiritual services that meet the needs and interests of all participants.

1.a.(7) The program may identify that certain services are provided through a contractual relationship with another provider in the community. Examples of services may include beauty services, massage, transportation, personal companion, art lessons, and voting registration.

1.b. Information about the scope of the program may be shared a variety of ways to raise awareness about the program to a variety of audiences. The ways to share information may include in writing, via video or audio recordings, on an organization's website, one on one or to groups, or with the assistance of an interpreter.

Examples of efforts to share information about the scope of the program could include invitations sent to regulatory officials to attend an open house at the organization; letters and marketing materials mailed to the local chapters of the office on aging, Alzheimer's Association, and stroke association; an email blast to members of the local case management association, or a public mailing to residents in the surrounding zip codes.

Intent Statements

The scope is defined at the level of the program/service and provides. It is not expected that the program/service share all information listed in 1.a. with every stakeholder, but that it provides the persons served, families/support systems, referral sources, payers and funding sources, and other stakeholders with relevant information that helps them understand what the program/service has to offer and determine whether it will meet the needs of the persons served. If the program is part of a continuum of services, the scope is defined for each program or specialty program within the continuum.
2.A. Resources
1.b. Resources/links for creating printed materials in language that can be understood by persons served include:
   - [www.sralab.org/lifecenter/resources/health-literacy-using-plain-language-health-communications](http://www.sralab.org/lifecenter/resources/health-literacy-using-plain-language-health-communications)
   - [www.ahrq.gov/topics/health-literacy.html](http://www.ahrq.gov/topics/health-literacy.html)
   - [www.cpha.ca/search/node?keys=health+literacy](http://www.cpha.ca/search/node?keys=health+literacy)
   - [www.who.int/classifications/icf/training/icfbeginnersguide.pdf](http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf)
   - [www.noslangues-ourlanguages.gc.ca/](http://www.noslangues-ourlanguages.gc.ca/)
   - [https://abclifeliteracy.ca/](https://abclifeliteracy.ca/)

Examples
When establishing the criteria for entry, transition, and exit, the capability of the program to provide the needed services is considered. While a program/service may use terms that are different than those above, the concepts are the same.

3.a. Entry criteria may also be called admission criteria, enrollment criteria, or move-in criteria.

3.b. Transition criteria may also be called transfer guidelines. These guidelines address transitions to other levels of care as well as transitions within a program/service.

3.c. Exit criteria may also be called agreement termination criteria, contract termination criteria, discharge criteria, or move-out criteria.

2.A. Intent Statements
The ability to provide the program/services defined in the scope statement is evidenced by adequate materials, equipment, supplies, space, finances, training, and human resources.

Examples
When a person is found ineligible for services:

a. The person is informed as to the reasons.

b. In accordance with the choice of the person:
   (1) The family/support system is informed as to the reasons.
   (2) The referral source is informed as to the reasons.

c. Recommendations are made for alternative services.

Examples
4.a. Informing persons as to why they are ineligible gives them the opportunity to more effectively target a service delivery system.

4.c. The person may verbally be given information about alternative services, or this information may be provided in writing for later use. In some cases, the referral source may be the more appropriate source for information about alternative services.
2.A. 5. Service delivery models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.

Intent Statements
The service delivery model and the strategies used are based on accepted practice, including consideration of areas such as information on the efficacy of specific techniques, pertinent research findings, protocols published by various professional groups, or approaches receiving professional recognition for achieving successful outcomes.

Examples
Evidence of conformance to this standard may be demonstrated through minutes of meetings in which these topics were discussed, literature available to the personnel in a program library, development of care paths or treatment guidelines, etc. Resources used in this process might include journal subscriptions, online access to learning opportunities and reference materials or journals, guest speakers, sponsoring educational events at the organization, inservice programs, journal clubs, collaborative resources, or education efforts with other area providers of services.

Resources
- Evidence Based Practice: www.eblcprograms.org/docs/pdfs/EBPs_101.pdf
- Evidence Based Leadership Council: www.eblcprograms.org/

2.A. 6. To facilitate integrated service delivery, each program/service implements communication mechanisms regarding the person served that:
   a. Address:
      (1) Emergent issues.
      (2) Ongoing issues.
   (3) Continuity of services, including:
      (a) Contingency planning.
      (b) Future planning.
   (4) Decisions concerning the person served.

   b. Ensure the exchange of information regarding the person-centered plan.

Intent Statements
This standard addresses the need for timely communication to ensure that services and programs are consistently provided, whether provided 24 hours a day, 7 days a week or on a part-time, scheduled basis.

Examples
Communication and collaboration may occur in the program/service through written or oral communication, such as electronic formats, log books, face-to-face meetings, progress notes, specialized communication devices, facilitative communication, handheld devices and computers, video or audio recordings, one-on-one teaching, etc.

2.A. 7. The program/service demonstrates:
   a. Knowledge of the legal decision-making authority of the persons served.
   b. When applicable, the provision of information to the persons served regarding resources related to legal decision-making authority.

Intent Statements
The persons served may not have the capacity or be of the age to make decisions in their own best interests. An individual may need to be assigned to make decisions regarding healthcare choices, financial decisions, or life care planning. Legal terminology may vary from jurisdiction to jurisdiction; e.g., healthcare power of attorney, power of attorney, and guardianship. The program/service should be able to discuss how it addresses the issue of the legal decision-making authority of the persons served.

7.b. Any limitation on a person's legal decision-making authority should be continued only as long as is appropriate and necessary. The program/service assists the person served and family/support system to access resources, such
as attorneys with expertise in this area, who can assist with facilitating changes, if appropriate, in legal autonomy status.

Examples

7.a. The legal decision-making authority of the persons served may be addressed by someone in the organization who has expertise in competency determination, through a screening process, in team conferences, etc. A provider could demonstrate knowledge of legal decision-making authority through a discussion with the surveyor of legal decision-making authority issues pertinent to existing state or provincial law, policies that outline levels of legal autonomy, inservices on issues of legal decision-making authority, and materials for personnel and the persons served that explain legal decision-making authority.

2.A. 8. When services are provided from or within a mobile unit, written procedures are implemented that address, at a minimum, the unique aspects of the following areas related to mobile settings:

a. Responsibilities of:
   (1) Drivers.
   (2) Service providers.

b. Confidentiality of:
   (1) Records of persons served.
   (2) Communication.

c. Privacy related to service delivery.

d. Accessibility.

e. Availability of information on resources to address needs unable to be met at the mobile setting.

f. Security of:
   (1) Medications provided from or within the mobile unit, when applicable.
   (2) Equipment and supplies used in service provision.
   (3) The mobile unit when not in use.

g. Safety of:
   (1) Records of persons served.
   (2) Personnel.

h. Maintenance of:
   (1) Equipment.
   (2) Vehicles.

Intent Statements

Mobile unit services are services provided from a vehicle such as a motor home or van that functions as a site for the program/service seeking accreditation.

Examples

8.b. Written procedures address confidentiality related to the use of mobile technology for documentation and telephonic communication about the persons served.

8.d. The mobile unit:
   ■ Provides adequate space for persons served to approach and move around inside of it.
   ■ Is equipped with a ramp, handrails, and adaptive equipment for use by personnel and/or persons served.
   ■ Operates from a location where there is ample parking.
   ■ Operates from a location that limits exposure to the sun and noise in the environment such as traffic noise.

8.f.(3) Security of the mobile unit when it is not in use might address the location where the unit is parked overnight and/or between stops, locking the unit, protection of records, and the use of security personnel or surveillance systems to monitor the unit.

8.g. Safety considerations might include communication systems available, availability of emergency procedures in the mobile unit, what to do in the event of an emergency situation, determination of the location where the mobile unit provides services, and minimum personnel that must be present during hours of operation.

8.h. Maintenance of mobile units might include keeping logs of mileage, gasoline use, oil changes, and tire wear.
2.A. 9. Each program/service implements procedures that address unanticipated service modification, reduction, or exits/transitions precipitated by funding or other resource issues.

Intent Statements
The program/service demonstrates its knowledge of funding sources and their expectations and timeframes for discontinuing or changing the program/service. While funding issues impact entry and exit decisions, the program/service consistently advocates for needs of the persons served.

Examples
A funding issue might be a change in the funding level of a contract for services, or, in Canada, a change in the government-imposed status of a person served. Other resource issues might include the unavailability of staffing due to an unexpected illness or inability of the person served to attend the program/services because a family member who usually provides transportation suffers an injury that prohibits him from driving.

2.A. 10. Based on the scope of services, there is a written agreement:

a. That is presented in an understandable format.

b. Of which a copy is provided to the person served:
   (1) For review prior to entry to the program.
   (2) After it is signed by all appropriate parties.

c. That is available for review by the person served.

d. That is signed by:
   (1) The person served.
   (2) The program’s representative.

e. That contains information regarding:
   (1) Entry:
      (a) Criteria.
      (b) Procedures.
   (2) Transition:
      (a) Criteria.
      (b) Procedures.
   (3) Exit:
      (a) Criteria.
      (b) Procedures.
   (4) Scope of services that will be provided.
   (5) Fee schedule.
   (6) Responsibility for payment of fees.
   (7) Refund policies.
   (8) Resources to address program or payer limitations.

Intent Statements
Information exchange promotes an understanding between the program and persons served regarding critical components of how service delivery is conducted. Information is shared at appropriate times to support transparency and knowledgeable decision-making.

Examples
Written agreements may be referred to as admission agreements, contracts, residence and care agreements, life leases or participant agreements.

10.b. Written agreements may be shared in a variety of methods at different points in time:
- In an admissions packet
- During a person-centered planning meeting
- During a transition planning or move-out discussion with persons served
- At any time if a person served requests to review it

10.e.(2) Transitions may be voluntary or involuntary and may be between levels of care such as assisted living and long-term care within the same organization or it may be transition from basic assisted living to a memory care program. Under certain circumstances, transitions may also include movement between one apartment or cottage to another or one room to another. Transitions may also be within an adult day program from basic ADL support to a level requiring more nursing services during participation hours.
10.e.(8) Limitations of the program could include space availability (e.g., a participant wishes to attend five days a week and space is available only for three days a week) or limited hours of operation (e.g., program closes at 5:00 p.m., but family would prefer to pick up the person served at 6:00 p.m.).

Resources to address payer limitations could include a benevolent fund or a scholarship fund that can be accessed by persons served under certain circumstance.

2.A. 11. The program provides opportunities to orient potential persons served and their families/support systems about the program in order to:
   a. Familiarize them with the:
      (1) Mission of the program.
      (2) Personnel.
   b. Determine their expectations.
   c. Provide information on:
      (1) The fee schedule.
      (2) Accepted payer sources.
      (3) Levels of assistance provided.

Intent Statements
In many cases, initial interactions may be a deciding factor in whether or not individuals seek services from a provider. Processes are helpful in ensuring that there is consistency in how interactions with those who may seek services from the program occur.

Examples
Opportunities to learn about the program could include visiting the program, a video tour, providing printed materials via mail or in person, reviewing information available on the organization’s website, having telephone calls between program personnel and the person served, and supplying audio recordings about the program.

- A couple stops by the program for information late in the afternoon. The receptionist, a new volunteer, refers to a handbook that includes a one-page guide on how to greet visitors, areas of the program to highlight, materials to provide to individuals making inquiries, and follow-up steps.

- The marketing or admissions staff of a program provides a “Welcome Visitor” workshop as part of new hire orientation and annually for all personnel who may be involved in visits of potential persons served.

2.A. 12. Based on the scope of services, written screenings/assessments are conducted:
   a. Prior to the initiation of services.
   b. At a frequency that is consistent with the needs of the persons served.
   c. In response to changes in care needs.
   d. In response to changes in preferences of the persons served.

Intent Statements
Communication between persons served and personnel in a program contributes to effective service planning. Information gained from the various screenings/assessments filters into the person centered plan as it evolves over time based on the changing needs and preferences of the person served.

Examples
- In Canada, external public sector/health authority case managers may provide an initial and ongoing assessments (e.g., RAI) for publicly funded/subsidized services to contracted service providers.

Examples of screenings/assessments might include:
- Physical examination conducted by the person’s served personal physician.
- Annual wellness assessment conducted by a wellness professional.
- Interdisciplinary team observation system that includes forms that are used by dining and housekeeping to identify unique needs of persons served.
- A record of a conversation that program personnel have with the family/support system of a person served addressing information such as medication needs, transportation, dietary preferences, and changes in participation hours.
Based on the scope of services of the program, initial and ongoing written screenings/assessments:

a. Address the following areas:
   - (1) Behavior.
   - (2) Cognition.
   - (3) Communication.
   - (4) Dental.
   - (5) Function.
   - (6) Health.
   - (7) Legal involvement.
   - (8) Medications.
   - (9) Nutritional.
   - (10) Pain management.
   - (11) Physical.
   - (12) Psychological.
   - (13) Relationships.
   - (14) Recreation and leisure.
   - (15) Social.
   - (16) Spiritual.
   - (17) Trauma.
   - (18) Others, as appropriate to the needs of the person served.

b. Identify:
   - (1) Prior daily routines.
   - (2) The preferences of the persons served.
   - (3) The choices of the persons served.
   - (4) The personal goals of the persons served.

c. Are used to develop person-centered plans for the persons served.

Examples

In Canada, external public sector/health authority case managers may provide an initial and ongoing assessments (e.g., RAI) for publicly funded/subsidized services to contracted service providers.

13.a.(5) Examples of function could be maintaining balance during mobility or the level of continence of the individual and how these impact participation in activities. Function may also include activities of daily living and instrumental activities of daily living such as paying bills, shopping, housekeeping, and laundry.

13.a.(6) Examples of health related information may include allergies, smoking cessation and weight maintenance, arthritis, heart health, diabetes, podiatry, ophthalmology, stroke recovery, hearing loss, vision loss, and oncology.

13.a.(7) Legal involvement may include if the person served is listed as a sex offender, convicted of assault or theft, restraining orders, or has a record of other serious offenses that may pose a risk to others. This type of information can be essential in developing an appropriate person-centered plan for the person served that considers situations that may pose a risk to that individual or others.

13.a.(11) An example of physical assessment might be regular skin checks or routine dermal inspection conducted by an appropriate practitioner who can identify potentially dangerous skin changes that require treatment.

13.a.(13) Examples of relationships may include a variety of interactions including those that are platonic friendships and those involving sexual intimacy.

13.a.(17) It is important to recognize that persons served may have a past traumatic experience that might impact their quality of life and the care provided. Trauma survivors, including veterans, survivors of large-scale natural and human-caused disasters, Holocaust survivors, and survivors of abuse are among those who may be receiving services. Any experience that threatened death or physical harm may be considered trauma, and witnessing of trauma events should also be considered. Knowledge of this trauma can then allow care to be provided in a manner that
minimizes the risk of re-traumatization and facilitates quality delivery of care.

13.a.(18) Examples of other information may include vocational capacity and sexual orientation.

13.b.(2)–(3) A person served might prefer mint ice cream, but might be given a choice between chocolate and vanilla. A person served may prefer a private room, but if not available, the person served may have a choice in roommate.

Resources

■ Trauma-Informed Care Implementation Resource Center:
  www.traumainformedcare.chcs.org

■ Guidance for a Trauma-Informed Approach; HHS Publication No. (SMA) 14-4884:

■ Key Ingredients for Successful Trauma-Informed Care Implementation:
  www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/

■ Podcasts:
  - Trauma Informed Care in Residential Long Term Care for Older Adults:
    www.insocialwork.org/
    episode.asp?ep=263
  - The Impacts of Trauma in Later Life:
    www.insocialwork.org/
    episode.asp?ep=208

2.A. 14. Based on scope and identified needs, person-centered plans are implemented for the persons served:

a. That are based on:
   (1) Initial and ongoing screenings/assessments.
   (2) Observations of the person served.
   (3) Preferences and choices of the person served.

b. That address:
   (1) Identified service needs.
   (2) Necessary:
      (a) Interventions.
      (b) Approaches.
      (c) Supports.
   (3) The types of services to be provided.
   (4) The intensity of services to be provided.
   (5) The frequency of services to be provided.
   (6) The goals of the person served.
   (7) Persons responsible for facilitating each goal.
   (8) The integration of available resources.
   (9) The choices and behaviors of the person served that pose a risk to his or her health or safety.
   (10) Transition/exit plans, as appropriate.
   (11) Identification of the preferences of the person served for involvement of members of the family/support system.
   (12) The changing lifespan issues of the person served.

c. That are monitored for progress toward accomplishment of the goals identified.

d. That are shared in an understandable manner with:
   (1) The persons served.
   (2) Other persons identified by the persons served.
   (3) Appropriate personnel.

Intent Statements

Person-centered plans will vary from simple to complex depending upon the needs of the person served, the level of activity, health concerns, etc. The concept of person-centered plans is to increase the integration of information about the person served into a centralized system. To foster efficiency and effectiveness of service delivery, personnel are able to access current information
about persons served from a variety of sources that feed into a central system.

Plans evolve over time as the individual changes. The program has a method for collecting information about each person’s preferences, choices, and needs through a variety of sources that may include observations of and interactions with the persons served, as well as initial and ongoing screenings, and assessments. The plans are documented, monitored for progress, and revised as the needs or preferences of the person served change.

Examples

14.a.(2) Examples of preferences vs. choices may include:

- A person served may prefer to take a walk every day at 8AM but that may not be possible in the setting, so the program offers the person served the choice to walk every day later in the morning or in the early afternoon when a volunteer is available to accompany them.

- A person served prefers to have pancakes every day for breakfast. Since pancakes are not on the menu every day, the program offers the person served the choice of having pancakes whenever they are on the menu.

- A person served prefers to sleep in until 11:00 a.m. every day. The program offers the person served the choice to wake at the time they want to wake. In this case, the preference and the choice may align.

14.b.(1)–(2) For individuals that have urinary incontinence, the program might identify if bladder control training, medications, or other nonsurgical approaches can help manage the condition.

For individuals with common skin problems, which could include excessive dry skin, eczema, increased fragility, and reduced sensation, the program might foster regular observation practices to identify skin changes, encourage use of appropriate lotions, or implement gentle hygiene techniques like patting rather than rubbing delicate areas when washing in order to promote skin integrity. If the skin integrity issues exceed the scope of the program, a referral may be made to a dermatologist or other professional to review the condition and perhaps prescribe a strong topical treatment.

14.b.(3)–(5) The organization identifies the type, amount, and duration of needed services chosen by the person served such as fitness, nutrition, social opportunities, home-making assistance, pastoral, or nursing/medical support services. Person-centered plans might be called resident file or participant file.

The identification of needs starts with the persons served application which is filled out by the prospective person served or with the assistance of a family member, admission coordinator, or marketing representative and may include lifestyle preferences, financial resources and basic healthcare information. Lifestyle preferences may include desire to participate in various activities, dining options, transportation needs, an individual’s rhythm of the day, and religious or spiritual preferences and choices.

The observed changes that any staff member, including those from activities, transportation, and dining, may be included in the person-centered plan. A program may also have members of the interdisciplinary team who identify and address concerns within their area of responsibility in order to be aware of changes in the needs of the persons served. This information may be helpful in developing and maintaining the person-centered plan.

Resources


- National Center on Advancing Person-Centered Practices and Systems: https://ncapps.acl.gov
2.A. 15. Based on the scope of the program, when a need for assistance is identified for a person served, the program offers assistance for activities of daily living in a manner that promotes:
   a. Independence.
   b. Safety.
   c. Dignity and self-worth.

2.A. 16. Based on the scope of the program, the service delivery team:
   a. Is determined by:
      (1) The screening/assessment process.
      (2) The person-centered planning process.
      (3) The goals of the person served.
      (4) The strategies utilized to achieve the goals.
   b. Includes:
      (1) The person served.
      (2) Members of the family/support system, in accordance with the preference and choice of the person served.
      (3) Personnel with the competencies necessary to evaluate the person served and facilitate the achievement of goals of the following types:
         (a) Behavior.
         (b) Cognition.
         (c) Communication.
         (d) Function.
         (e) Health.
         (f) Physical.
         (g) Dental.
         (h) Nutritional.
         (i) Pain management.
         (j) Psychological.
         (k) Recreation and leisure.
         (l) Social.
         (m) Spiritual.
         (n) Others, as appropriate to the needs of the person served.
   (4) Other stakeholders, as appropriate.

Intent Statements
The composition of each person's team is determined through the screening/assessment and person-centered planning processes. The scope of the program guides the type of competencies needed by personnel since programs vary regarding the services offered. The team is a dynamic group of individuals that may change during the person's participation in the program. Some personnel may be active team members for the entire length of a person's participation in the program while others may become active members of the team as the need for services or expertise is identified. Frontline caregivers are included as integral members of the team and provide input to the person-centered plan and services to be provided.

Examples
16.b.(3)(d) Examples of personnel able to assess function might include a physical therapist, occupational therapist, social worker, or nurse.
16.b.(3)(f) Physical goals might be addressed by personnel who are knowledgeable about skin integrity risk factors and interventions to promote skin health and minimize wounds. Personnel might include, but are not limited to, direct care personnel, nurses, or other clinical personnel.
16.b.(4) If input from a particular discipline is required for the person served to achieve identified goals and that discipline is not part of the organization's personnel, arrangements might be made to seek input from a person not employed by the program to participate on the team when needed.
2.A. 17. Based on the scope of the program, to ensure achievement of the goals of the person served, the personnel who collaborate with and coordinate services for each person served:

a. Demonstrate appropriate competencies as defined by the program.

b. Are identified to:
   (1) The person served.
   (2) The family/support system, in accordance with the preference and choice of the person served.

c. Have the authority to coordinate the provision of services.

d. Are knowledgeable about the person’s preferences, choices, and personal goals.

e. Are available to interact with:
   (1) The person served.
   (2) The family/support system, in accordance with the preference and choice of the person served.
   (3) Other relevant stakeholders.

f. Provide appropriate orientation to:
   (1) The person served.
   (2) The family/support system, in accordance with the preference and choice of the person served.

g. Ensure communication with:
   (1) External sources.
   (2) Internal sources.

h. Integrate the available financial information into decision making about the provision of services.

i. Facilitate the involvement of the person served throughout the service delivery process.

j. Ensure that transition/agreement termination arrangements are completed.

k. Ensure that transition/agreement termination recommendations are communicated to appropriate stakeholders.

l. Facilitate the implementation of transition/agreement termination recommendations when appropriate.

Intent Statements
The program determines the individuals who will fulfill these responsibilities. If responsibilities are shared by multiple persons for a person served, the program identifies who has ultimate responsibility for the shared areas and how efforts will be coordinated on behalf of the person served. Persons served and the family/support systems know who is coordinating services for the person served.

Examples
Personnel in this role might be called coordinators, case managers, or resident services coordinators.

17.g. Service delivery personnel may identify a skin integrity risk for a person served and report this information to a clinical expert who can review and treat the issue to prevent skin breakdown or infection.

2.A. 18. Based on scope, the responsibilities of the service delivery team include:

a. Conducting initial and ongoing screenings/assessments.

b. Reviewing relevant reports to facilitate initial and ongoing screenings/assessments.

c. Assisting persons served to set personal goals.

d. Identifying resources.

e. Integrating information on resources into program planning.

f. Establishing the person-centered plan.

g. Integrating information on resources into program implementation.

h. Implementing the person-centered plan.

i. Providing education and training.
Section 2.A. Program/Service Structure

j. Modifying the person-centered plan.
k. Ensuring that team members change based on the needs of the person served.
l. Partnering with the person served to achieve that person's goals.
m. Establishing the transition plan.
n. Establishing the agreement termination plan.
o. Transitioning the persons served to other levels of care and/or other services/program, as needed.
p. Referring the persons served to other services/programs, as needed.
q. Communicating with relevant stakeholders.
r. Participating in performance improvement.

f. Store information utilizing a system that is accessible to the team.
g. Consider the impact of its decisions on:
   (1) The person-centered plan for the person served.
   (2) The entire service delivery team.

Examples

Examples of communication and collaboration by program personnel might include written communication, log books, face-to-face meetings, morning rounds, or in-services.

- The personnel working at night observe that a person served consistently tries to exit the program around 11:00 p.m. In discussions with family members, it is discovered that the individual used to work nights as a security guard. The personnel working at night take the person served on rounds with them and have the person “check” things on the unit. Personnel communicate this to colleagues working days who better understand the need for the person to sleep during the day.

- A wife is the primary caregiver for the person who participates in the program. The wife informs the program personnel about the contingency plan for alternative transportation so the person served can still attend the program in the event of an emergency.

2.A. 20. As much notice as possible regarding transition or exit is provided to:
   a. The person served.
   b. The family/support system, in accordance with the preference and choice of the person served.
   c. Personnel.
   d. Other relevant stakeholders.

Intent Statements

The responsibility of the team is determined through the screening/assessment and person-centered planning processes and is based on the needs of the persons served and, is activated when needed and may change during the person’s participation in the program.

2.A. 19. In order to communicate and facilitate an integrated approach, the interdisciplinary team members, including team members working on all shifts and days, as well as the person served:
   a. Are aware of the person-centered plan for the person served.
   b. Implement the person-centered plan for the person served.
   c. Modify the person-centered plan as the status of the person served changes.
   d. Participate in making decisions concerning the person served.
   e. Ensure that decisions are communicated to the entire team.
2.A. 21. To facilitate the continuity of services, at the time of transition or exit, the program communicates information related to the person's participation in the program:
   a. Including:
      (1) Advance directives.
      (2) Assistance needed with activities of daily living.
      (3) Behavioral interventions.
      (4) Family system support.
      (5) Healthcare information.
      (6) Medications.
      (7) Personal preferences.
   b. To relevant stakeholders.

Intent Statements

Communicating essential information is important when a person served transitions within the program or to another setting.

Examples

21.a.(5) Examples of health information may include allergies, past medical history, and diagnosis.
21.a.(7) Examples of personal preferences may include favorite foods, waking time, and meaningful friendships that have developed.
21.b. Examples of relevant stakeholders may include payer, another program and family/support system.

- To facilitate a smooth transition to the hospital for a surgical procedure, the program personnel might prepare a written summary that accompanies the person served. Information important to continuity of care and an understanding of the needs and daily routine of the person served may be included.
- Following a month's stay for rehabilitation for a hip replacement, the program might prepare a summary that it provides to the person served to take home. This summary may be given to the adult day program where the person served participates.

2.A. 22. Family/support system discussions, when appropriate:
   a. Are arranged.
   b. Are documented.
   c. Are held at a frequency consistent with the needs and choices of:
      (1) The person served.
      (2) The family/support system.
   d. Are scheduled at a time that is convenient for:
      (1) The person served.
      (2) The family/support system.
   e. Include those team members who are necessary to discuss issues of importance to:
      (1) The person served.
      (2) The family/support system.
      (3) The service delivery team.

Examples

Family/support system discussions may be conducted on site or through other mechanisms such as telephone conference calls.

Program personnel observe changes in behavior or routine of persons served and might contact family/support systems to discuss the observations.

- Between scheduled care planning meetings, an individual may request a meeting to discuss a change in her spouse's condition. Program personnel responsible for the person served might schedule a time to meet when the individual and key personnel are available.
- A person served may be admitted to the program because the primary caregiver's new job no longer makes it possible to provide for care in the home. The person served may not be participating in activities. The primary caregiver may be called to discuss how to help with adjustment.
2.A. 23. In accordance with the choice of the person served, the program partners with the family/support system throughout the service delivery process, including:
   a. Ongoing consideration of the family’s/support system’s:
      (1) Ability and willingness to support and participate in the person-centered plan.
      (2) Composition.
      (3) Interpersonal dynamics.
      (4) Different methods of:
          (a) Engagement.
          (b) Communication.
          (c) Coping.
          (d) Problem solving.
      (5) Strengths and limitations.
      (6) Knowledge base.
      (7) Expectations of the program.
      (8) Educational needs.
      (9) Responsibilities, including decision making regarding:
          (a) Healthcare of the person served.
          (b) Finances of the person served.
          (c) Lifestyle of the person served.
          (d) Other, as appropriate.
      (10) Geographic proximity to the person served.
      (11) Preferred method of communication.
      (12) Preferred timing of communication.
   b. Financial, social, or cultural factors that might influence the person-centered plan.
   c. Health status of the family/support system.

Intent Statements
Trust and collaboration between families and personnel develop when the complexities of the family/support system are understood. All parties can more effectively work together to support the dignity of the person served.

Examples
Assessments may consider:
- Family’s/support system’s ability to provide transportation.
- Family’s/support system’s ability to provide clothing that supports self-care.
- Interactions between the person served and the spouse/significant other of the person served, caregivers, friends, peers and community.
- Composition such as the nuclear family, extended family with multiple children, grandchildren, blended families, friends, and neighbors.

Resources
- Easter Seals has online resources for family caregivers: www.easterseals.com/explore-resources/for-caregivers/
- The National Center on Caregiving: https://caregiver.org
- The Canadian Caregiver Coalition: www.ccc-ccan.ca/content.php?doc=29

2.A. 24. Safety and security measures:
   a. Are consistent with:
      (1) The behavioral needs of the persons served.
      (2) The cognitive needs of the persons served.
      (3) The physical needs of the persons served.
   b. Promote:
      (1) Socialization.
      (2) Interaction with the environment.
   c. Address:
      (1) Chemical use, abuse, or dependency.
      (2) Elopement risks.
      (3) Equipment safety.
      (4) Late pick up or no pick up.
      (5) Mental health issues.
(6) Physical hazards.
(7) Physically aggressive behaviors.
(8) Self-injurious behaviors.
(9) Sexually-inappropriate behaviors.
(10) Suicidal ideation.
(11) Suspected neglect.
(12) Suspected abuse.

d. Are addressed in personnel training at least annually.

Intent Statements
These measures address behavior, cognitive, and mobility needs of persons served.
It is important for all persons served to feel safe and secure in the program but not feel restricted. Persons served should also feel that they have choices. Individuals who wander or exhibit various behaviors still need to socialize as an important aspect of daily life, and there should be options for how and where that can safely occur.

Examples
Outdoor areas could be available and usable for persons served desiring to spend time outside. They are safe for persons served and promote interaction with each other and with nature.
Safety and security measures could be addressed architecturally when designing new areas or remodeling and when thinking about where and when to schedule activities.
Safety and security measures may be included as part of personnel training on related health and safety practices, as well as other types of personnel training that is conducted at least annually.

24.c.(6) Physical hazards might include risk of falls due to physical limitations such as weight, lack of balance, or limited vision, and factors in the environment such as poor lighting or uneven floor coverings.

Resources
- ACL Elder Justice: https://elderjustice.acl.gov
- National Center on Elder Abuse: https://ncea.acl.gov

2.A. 25. When there is a need to address behaviors, personnel, on an ongoing basis:
a. Observe the person served.
b. Describe the behavioral event.
c. Understand the behavioral event:
   (1) From the perspective of the person served.
   (2) From the perspective of personnel.
   (3) As communication on the part of the person served.
d. Analyze the potential causes.
e. Determine the appropriate approach, treatment, and/or supports necessary.
f. Ensure the safety of:
   (1) The person served.
   (2) Other persons served.
   (3) Personnel.
   (4) The family/support system.
g. Implement the appropriate interventions.
h. Assess the results.
i. Share the information learned with:
   (1) The person served.
   (2) Other appropriate personnel.
   (3) The family/support system, in accordance with the preference and choice of the person served.

Intent Statements
Persons served may do things that personnel might not always fully understand, yet all behavior has meaning. When personnel seek to understand what causes these behaviors, they can more effectively support the person served.

2.A. 26. The program implements a policy regarding the use of chemical or physical restraints that addresses whether and under what circumstances:
a. Chemical restraints will be used.
b. Physical restraints will be used.
27. The program implements written procedures regarding the use of chemical or physical restraints that address:
   a. Prevention of unsafe behaviors.
   b. Alternative interventions used in an effort to avoid the use of chemical or physical restraints.
   c. If the program uses chemical or physical restraints:
      (1) The use of chemical or physical restraints only after nonpharmacological approaches have been exhausted.
      (2) The use of chemical or physical restraints only temporarily in an emergency to protect the person served or others from injury or serious harm.
      (3) Who is responsible for authorizing the use of chemical or physical restraints.
      (4) Time-limited use.
      (5) Disclosure when used.
      (6) Strategies for discontinuation.
      (7) Reviews for discontinuation.
      (8) Documentation in the records of the persons served.

Intent Statements
To respond to behaviors, programs should seek therapeutic approaches that minimize the use of chemical or physical restraints. Chemical or physical restraints should not be used for discipline or convenience, and might be considered only temporarily in an emergency to protect the person served or others from injury or serious harm.

27.b. For programs that are restraint free, the expectation is that the program implements written procedures that identify the strategies implemented in lieu of the use of chemical or physical restraints and the approaches used in situations in which persons served might put others at risk of injury or serious harm.

Examples
27.c.(6) If a program has used chemical or physical restraints, strategies for discontinuation may be a process of multiple phases or steps involving reduction leading to discontinuation over a period of time.

Resources
Resources to assist with reduction in use of antipsychotic medications include:
- The Canadian Foundation for Healthcare Improvement: www.cfhi-fcass.ca/What-WeDo/reducing-antipsychotic-medication-use-collaborative
- National Nursing Home Quality Improvement Campaign: www.nhqualitycampaign.org/goalDetail.aspx?g=med

28. The program implements written procedures that address compliance with all applicable laws and regulations pertaining to medications and controlled substances, including:
   a. Medication storage.
   b. Medication administration.
   c. Timing of administration.
   d. Location of administration.
   e. Self-administration.
   f. Medication management/assistance.
   g. Medication reconciliation.
   h. Medication disposal.
   i. Over-the-counter:
      (1) Medications.
      (2) Supplements.
      (3) Vitamins.

Intent Statements
Because laws and regulations vary tremendously on these topics, the organization must not only have written procedures in place regarding medications and controlled substances, it should also be able to explain to surveyors how these procedures are kept current with applicable requirements.

Examples
If a state/province or other jurisdiction has legalized marijuana use, your policies and procedures may include policies related to marijuana use or administration that could address whether
a physician order is required, marijuana tracking and storage, and ingestion methods acceptable for the service delivery setting.

28.g. Medication reconciliation is a formal process in which healthcare providers partner with persons served and families/support systems to ensure that accurate and complete medication information is shared at transitions of care and at other points in time such as when different medications are being prescribed to the person served.

Resources


2.A. 29. Personnel responsible for medications receive competency-based training on medication:

a. Upon hire.

b. Annually.

c. That includes:

(1) Written procedures that address medications.

(2) Actions to take in case of an emergency.

(3) Administration/assistance.

(4) Medication reconciliation.

(5) Dispensing.

(6) Disposal.

(7) Documentation.

(8) Errors.

(9) Implications of abrupt discontinuation.

(10) Implications for management of multiple medications.

(11) Indications and contraindications.

(12) Obtaining medication.

(13) Written procedures for handling controlled substances.

(14) Side effects.

(15) Storage.

d. That addresses compliance with all applicable laws and regulations pertaining to:

(1) Medications.

(2) Controlled substances.

Examples

29.d.(2) Training may address how personnel could comply with applicable laws and regulations pertaining to controlled substances such as medical marijuana (cannabis).

2.A. 30. The following are addressed in policy:

a. Advance directives.

b. Resuscitation, including:

(1) Provision of information for making a decision.

(2) The right to refuse resuscitation.

c. Any legal requirements related to:

(1) Advance directives.

(2) Resuscitation.

d. Provision of information on the organization’s procedures concerning advance directives to:

(1) The persons served.

(2) The families, support systems, or caregivers of the persons served.
An organization has policies and procedures in place to ensure that all personnel caring for persons served are aware of their desires for end-of-life decisions and care.

2.A. 31. Personnel demonstrate competency in the use of technology to support the day-to-day operations of the program.

Intent Statements
When programs use technology, it is important that personnel are educated about how this technology is integrated into their work. The investment in technology is more fully realized when personnel demonstrate consistent and effective use.

Examples
Examples of ways that personnel may demonstrate competency may include:
- A colleague does a side-by-side monitoring of how a staff person records attendance data in the billing database to provide tips on how it may be done with a higher level of accuracy.
- The education coordinator observes personnel recording blood pressure on a digital monitor and provides feedback to them.
- The program may implement a process for ordering supplies or food through an automated system. Existing personnel participate in training at the time of implementation. This training is then incorporated in the new hire orientation for all new dining service employees.

2.A. 32. If the person served uses assistive technology, electronic aids to daily living, environmental controls, equipment, environmental modifications, and/or personal emergency response systems, the program, on an ongoing basis:
   a. Determines that the technology and/or equipment:
      (1) Functions properly.
      (2) Achieves the intended purpose.
   b. Notifies the appropriate designee, as needed.
   c. In accordance with the person-centered plan, incorporates the technology and/or equipment into service delivery.

2.A. 33. The physical plant of the program:
   a. Has equipment available to meet the individual needs of the persons served.
   b. Facilitates the appropriate use of therapeutic equipment.

Intent Statements
The physical environment facilitates the accomplishment of the individual plans and predicted outcomes of the persons served; promotes their dignity, self-worth, privacy, and quality of life; and it supports their ability to make choices in their daily routines. The design of the physical environment, the equipment needed, and other aspects of the environment vary depending upon the ages of the persons served.

Examples
The patio area accommodates those with mobility issues. It has been designed for usability, with protection from the elements.
In all reading areas, there is sufficient lighting for persons with low vision.
The organization has space for parties to celebrate holidays, birthdays, anniversaries, and events of family importance.
The bathrooms are designed to accommodate the use of wheelchairs.
The beds provide for the safety and comfort of persons served.
2.A. 34. Based on its scope of services, the program has a written philosophy of health and wellness for the persons served that:
   a. Is implemented to:
      (1) Address:
         (a) Function.
         (b) Quality of life.
      (2) Promote healthy aging and well-being.
   b. Addresses aging in place.
   c. Is shared with:
      (1) The persons served.
      (2) Families/support systems.
      (3) Personnel.

Examples
Well-rounded wellness programming may address aspects such as physical, social, spiritual, emotional, occupational, and intellectual.

A program’s philosophy may be documented separately or included in other documents such as a vision and values statement, mission statement, or marketing materials.

An emphasis might be placed on the following:
- Maximizing or maintaining independence of persons served.
- How changing acuity needs will be addressed, such as whether hospice services will be offered in all units or in a specialized unit or a local hospice.

Resources
- International Council on Active Aging: www.icaa.cc
- National Wellness Institute: www.nationalwellness.org

2.A. 35. Wellness for the persons served is promoted through activities that:
   a. Are based on input from the persons served.
   b. Consider input from families/support systems.
   c. Are purposeful.
   d. Provide for daily structured and unstructured activities.
   e. Promote healthy behavior.
   f. Meet their interests.
   g. Align with their cognitive capabilities.
   h. Align with their communication capabilities.
   i. Reflect their choices.
   j. Promote their personal growth.
   k. Enhance their self-image.
   l. Improve or maintain their functional levels whenever possible.
   m. Allow for social interaction.
   n. Allow for autonomy.
   o. Include opportunities for community integration.
   p. Are documented in the individual plan for each person served.

Examples
Well-rounded wellness programming may address aspects such as physical, social, spiritual, emotional, occupational, and intellectual.

Part of wellness might include identification and celebration of lifecycle events that are important and meaningful to the persons served, families and support systems, and personnel who provide care and services to these individuals.

Wellness may also include, based on the interests of the person served, opportunities to share talents and skills, mentor, or teach others.

35.d. Examples of unstructured activities might include:
- A person accustomed to working nights enjoys late night movies, the radio, a good book, or time to surf the internet.
- The availability of jigsaw puzzles, crossword puzzles, games, cards, or other similar activities may encourage persons served to participate either alone or with others.
- Large print books may be available or can be obtained from a local library that visits biweekly.
- Persons served plant seasonal flowers or create an herb garden.
2.A. 36. When the program provides scheduled activities, information regarding the activities is:
   a. Communicated in a way that is understandable to the persons served.
   b. Accessible to:
      (1) The persons served.
      (2) Their families/support systems.

2.A. 37. Based on the program’s scope of services and on an assessment/screening of the learning needs and preferences of the persons served, the program provides or arranges for:
   a. Formal and informal educational opportunities.
   b. Access to:
      (1) Computers.
      (2) The internet.
      (3) Information of interest.
      (4) Health information.
      (5) Other media.

Examples
The program supporting group learning activities such as current events discussion and might invite local experts or persons served to provide lectures on art, history, music, political science, or other topic of interest to persons served.

The program might schedule outings or notify persons served of events at the local community college including movies, art, music, and education.

The program may be set up with computer and internet access on-site for use by persons served, or it may identify community resources such as the library, recreation center, or senior center where persons served may go for instruction and to use a computer.

Information on health related issues and topics of interest might be available through the internet or through books, pamphlets, or presentations, a health fair hosted by the program, or by attending a community health fair.

2.A. 38. When the program provides dining services, it:
   a. Seeks input from the persons served regarding its dining services.
   b. Uses the information to improve its dining services.
   c. Promotes access, in accordance with the written agreements of persons served, to:
      (1) Nutritious meals.
      (2) Snacks.
   d. Allows persons served to:
      (1) Select what they want to eat.
      (2) Dine with:
         (a) Members of their families/support systems.
         (b) Friends of their choosing.
   e. Has sufficient capacity to:
      (1) Prepare appropriate food.
      (2) Deliver appropriate food.
      (3) Arrange for appropriate food.
   f. Prepares food in a manner that is:
      (1) Sanitary.
      (2) Safe.
   g. Considers dietary requests.
Examples

A committee of persons served may work with the dining services department to provide suggestions regarding menu planning.

A committee of persons served that is planning social events for a holiday may offer suggestions to personnel regarding snacks that would be preferred by event participants.

The program may implement a take-out or delivery service for persons served in which participants may pre-order meals.

Alternate selections to the daily menu, in line with preferences of persons served, might be available.

Vegetarian options are indicated on the menu.

State, local or provincial inspection reports and dietician reports might be useful to determine how the program addresses food preparation.

38.c.(2) Snacks may be obtained through a marketplace, a café, or other venue depending on the written agreements.

39. If the program serves any persons who require respiratory management, including ventilatory assistance, it demonstrates:

a. The establishment of personnel competencies.

b. A mechanism to demonstrate the level of competency achieved.

c. The availability of appropriate equipment and supplies, including:
   (1) Cough assistance devices.
   (2) Suctioning equipment.
   (3) CPAP/BIPAP.
   (4) Oxygen.

d. The utilization of appropriate equipment.

e. The maintenance of appropriate equipment.

f. The availability of a pulmonologist.

g. The availability of respiratory therapy services 24 hours a day, 7 days a week.

h. Training for:
   (1) The person served.
   (2) The family/support system.

i. Emergency plans that take into consideration the unique needs of persons who require respiratory management.

j. If ventilator dependent:
   (1) Availability of portable ventilators.
   (2) Ongoing assessment of the need for ventilatory support.
   (3) Ventilator weaning protocols.

Intent Statements

Persons served who have respiratory insufficiency are vulnerable and present unique needs. Respiratory management might be needed by persons with impairments of the lung, respiratory muscle, or swallow function who would benefit from interventions to improve or manage respiratory conditions. Interventions may range from non-invasive respiratory management through ventilator dependence.

Examples

Respiratory management may be required for persons served due to premorbid conditions such as asthma or COPD, as well as those persons served whose respiratory function has been affected by their admission diagnosis; e.g., spinal cord dysfunction, stroke, or brain injury, or those who have a tracheostomy. Other conditions that might require respiratory management include dysphagia, sleep apnea, pneumonia, lung cancer, pneumothorax, or respiratory failure.

39.g. Availability of respiratory therapy could be provided by nursing, therapy, or other health-related personnel with a degree that demonstrates competency in the respiratory therapy services needed by the person served.

40. When a person served or someone who is of significance to a person served dies, opportunities to express grief and remembrance are provided to:

a. Persons served.

b. The family/support system.
c. Personnel.
d. Other stakeholders.

2.A. 41. The records of the persons served include, when applicable:
   a. Identification data.
   b. Advance directives.
   c. Emergency contact information.
   d. Substitute decision maker who has been appointed for the person served, including:
      (1) Name.
      (2) Contact information.
      (3) Verification of the appointment.
   e. Medication information.
   f. Healthcare providers involved in the care of the person served, including:
      (1) Name.
      (2) Contact information.
   g. Medical information.
   h. Reports for initial assessments.
   i. Reports for ongoing assessments.
   j. Reports from referral sources.
   k. Reports of service referrals by the program.
   l. Reports from outside consultants.
   m. The person-centered plan of the persons served.
   n. Clinical entries related to the services received, as appropriate.
   o. Release forms.
   p. Discharge/transition summaries, as appropriate.

2.A. 42. The program works with local community leaders in emergency preparedness concerning the unique needs of persons served to address:
   a. Emergency preparedness.
   b. Power restoration.
   c. Evacuation.
   d. Transportation.
   e. Shelter.
   f. Recovery.

Intent Statements
The program works with community leaders in emergency preparedness (e.g., civil defense, homeland security, Red Cross) to educate them about the unique needs of persons served, including persons with dementia if applicable to the program, and how to ensure that those needs can be met in the event of an emergency.

42.f. Recovery after a disaster means the return of the person served to the home or community setting.

Examples
Programs could communicate about the unique needs of the population served with local community leaders who might work in fire departments, hospitals, pharmacies, first responder organizations, or other community organizations. "Work with" could be that aging services providers are involved in local meetings, serve on a local committee, share information via email with a local agency or organization to strategize regarding emergency preparedness topics and the unique mobility, cognitive or other issues that might be useful for community leaders to be aware of regarding the population served by the aging services provider.

42.f. Recovery might include transportation from the recovery center; home repairs needed due to damage from fire, water, or wind; utility recovery; or public health assessment for safe/healthy living conditions.

2.A. 43. The program identifies:
   a. The individuals who have the responsibility and authority to manage key components of the program.
   b. The skills and competencies required to perform as a program manager.

Examples
A program may have more than one position identified as leadership. There may be job descriptions that identify responsibilities and competencies for the leadership.
Staff requirements may include previous experience in working with person-centered care and in person-centered homes.

2.A. **44. Personnel are consistently assigned to each person served to meet his or her needs.**

**Intent Statements**

Strong relationships are central to quality care for persons served and families/support systems. Consistent assignment, which may also be called primary assignment, means that persons served see the same caregivers almost every time the caregiver is on duty. While not excluding a system of rotation, consistent assignment benefits both the persons served and the caregiver in the following ways:

- Prevents confusion of the persons served about the identity of their caregivers
- Builds and maintains relationships
- Decreases stress
- Increases caregiver retention
- Enhances caregiver knowledge

**Examples**

A full-time caregiver may be assigned the same group of persons served for the five days the caregiver is scheduled to work. The two days of the week that person is not schedule the same part-time caregiver works with that group of person served. By implementing this approach the persons served have relationships with two caregivers who know them well rather than seven caregivers who may rotate daily and not know their preferences. Each quarter these two caregivers are given the opportunity to work with an alternative group of residents in order to gain additional insights and knowledge.

In a small program all staff may consistently work with all persons served through daily interactions.

During the initial orientation and training period, staff work on a variety of assignments in an effort to get introduced to each person served and other personnel. After the initial rotation, the new personnel are assigned to a regular assignment.

Dining personnel may serve the same group of tables for the days they are scheduled to work. They become familiar with the preferences and dietary needs of the persons served.

Each discipline may have a system whereby assignments of individual staff members are rotated to enhance the expertise of personnel in all the areas. If such a system is used, the persons served are notified before a rotation ends and are introduced and oriented to any new personnel assigned to care for them.

When scheduling does not permit consistent assignments, providers demonstrate to the persons served that they have knowledge of other team members’ work through their follow through with the person-centered plan that has been established. If a program utilizes temporary, contract, or per diem personnel, it strives for maximum consistency and continuity of care through personnel assignments and scheduling.

2.A. **45. To fulfill the program’s commitment to respond to the changing needs of the persons served, education is provided:**

a. **To:**

   (1) **Personnel.**
   (2) **Volunteers.**

b. **On:**

   (1) **Indications that the status of the person served has changed.**
   (2) **How to respond to information about persons served that may be reported by other sources.**
   (3) **How to protect the privacy of the persons served.**
   (4) **How to protect the dignity of the persons served.**
   (5) **How to, on an ongoing basis:**
      (a) **Observe for changes in persons served.**
      (b) **Communicate observed or reported changes.**

**Examples**

45.b.(1) A person served in an adult day services or home and community services program might not be able to communicate their needs as clearly...
during programming or may have more difficulty completing activities of daily living. In a residential setting, security personnel may have had to respond frequently to the fire alarm sounding in an apartment due to the oven being left on and burning food. Housekeeping might notice that a person served is no longer able to care for a pet and the pet is soiling the apartment to the point that there is odor in the common areas. Dining personnel may observe that a person served is having more difficulty feeding himself and safely swallowing solid foods at meals in the dining room.

45.b.(2)–(3) Education might address if personnel involved in activities or caregiving notice a significant change in a person served, they know to share that information with their manager, who then shares it with an administrator. The education might also address key privacy considerations such as how such information is shared with the manager and not shared with other employees.

2.A. 46. Leadership fosters a continuous learning environment for personnel that:
   a. Recognizes and respects individual:
      (1) Learning styles.
      (2) Needs.
      (3) Strengths.
   b. Provides and evaluates:
      (1) Teaching.
      (2) Coaching.
      (3) Modeling.
      (4) Supervision.
      (5) Feedback.
   c. Measures the effectiveness of the techniques used in the learning environment against a performance target.

Intent Statements
Education of personnel who care for the persons served has been identified as a key component of quality service delivery. Leadership ensures that the program has processes in place for initial and ongoing education designed to meet the needs of each staff member. The program identifies the best way for each of its staff members to learn. For some it is in a classroom; for others it is a hands-on approach with a return demonstration; for others it is self-directed, computer-based education; and for others, it is a group discussion. Leadership ensures that personnel receive the education they need in the style best suited to their needs.

Examples
There may be opportunities for personnel to evaluate the program’s teaching mechanisms, how they have been coached, and the feedback they have received from their supervisors. Leadership models the desired behaviors for personnel.

Direct care personnel might need to make on-the-spot decisions that have traditionally been first cleared with their supervisor. Supervisors might need ongoing coaching to help them empower and support the direct care personnel to be decision makers.

Persons served, families/support systems, and personnel may be involved in the creation of a curriculum as well as in the initial and ongoing educational initiatives. Direct care personnel might have a more in-depth curriculum than other personnel who work in the program.

46.c. Potential measures of the effectiveness of learning techniques may include:
   ■ Assessment of learning styles, needs, and strengths.
   ■ Success of coaching.
   ■ Appropriateness of level of supervision.
   ■ Feedback regarding quality, quantity, or access to learning techniques.

2.A. 47. To enhance recruitment and retention of personnel, the program:
   a. Demonstrates outreach to expand its future workforce.
   b. Provides opportunities for career development.
   c. Provides mechanisms for personnel to:
      (1) Recognize successes.
      (2) Acknowledge challenges.
(3) Solve problems.
(4) Participate in the service delivery planning process.
(5) Participate in program development.

Intent Statements

The field of aging services continues to face significant workforce challenges. This standard addresses how programs can proactively focus on finding talent within current personnel and also strategically thinking about nontraditional candidates.

Examples

To tap into potential sources for employees or volunteers, program may have leaders attend functions and advertises job opportunities to retired teachers, department of aging programs for retired workers, high school student exchange programs and international cultural exchange programs.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written program entry criteria
- Program enrollment criteria
- Admission packet
- Program description
- Outcomes system description
- Policy and procedures for move-in, admission, program entry
- Website information
- Video about the program
- Residency and care packet including details regarding housing, services, fees, and other information
- Transfer guidelines
- Agreement termination criteria
- Contract termination criteria
- Discharge criteria
- Move-out criteria
- Notes regarding progress of persons served
- Written procedures regarding use of mobile technology for service delivery
- Maintenance logs from mobile units
- Admission agreements
- Contracts
- Refund policies
- Written agreement for services
- Screening/assessment tools
- Person-centered plans, care plans or service plans
- Procedures for compliance with medication-related laws and regulations
- Advance directives
- Written philosophy of health and wellness
- Records of person served
- Policy on use of chemical and physical restraints
- Written procedures addressing organization's approach to the use of chemical and physical restraints
- Documentation of competency-based staff training
- Documentation of competency-based volunteer training
- Activities schedule
B. Residential Communities

Applicable Standards
The standards in this subsection apply to all Aging Services residential programs:
■ Assisted Living (AL)
■ Person-Centered Long-Term Care Community (PCLTCC)
■ Continuing Care Retirement Community (CCRC)

2.B. 1. Service delivery planning considers:
   a. The changing needs and expectations of current and prospective persons served, including:
      (1) Dining.
      (2) Healthcare.
      (3) Housekeeping.
      (4) Maintenance.
      (5) Security.
      (6) Social interaction.
      (7) Transportation.
      (8) Other services.
   b. The changes in resources necessary to address those needs.

Intent Statements
As the population changes, services may be offered by program personnel that may not be included in the written agreement. Over time these individual situations may evolve into mainstream services that may impact resources utilization, budgeting, staffing, and expectations of persons served. When these services are unintentionally provided, this results in what may be referred to as service creep.

Examples
The department coordinator may initiate a planning discussion at a staff meeting regarding daily bed making services. The objective of the discussion may be to determine how to fulfill this person served preference without increasing persons served fees or adding additional personnel. The planning may include looking at numbers of requests and personnel statistics in order to assess the feasibility.

1.a.(6) Social interactions might include maintaining friendships using social media, accessing learning opportunities, or maintaining intimate relationships including sexual intimacy.

2.B. 2. The program implements policies and procedures regarding how it provides, arranges for or assists with arrangements for the following services:
   a. Health-related services.
   b. Rehabilitation services.
   c. Social services.
   d. Housekeeping services.
   e. Laundry services.
   f. Security services.
   g. Transportation services.

Examples
Policies and procedures may address the following:
■ Credentialing of physicians and other clinicians who provide services on-site.
■ Operations of the on-site medical clinic.
■ Who provides medical services.
■ What medical services are covered in the daily/contract/monthly fee.
■ Services that are billed through Medicare/Medicaid or private insurance.
■ Services that are provided on-site.
■ Services that are provided by referral.
■ Whether persons served may continue to see their own private physicians rather than the physician who comes on site.
■ Facilitation and supervision of therapeutic recreation activities.

2.B. 3. Dependent on the needs of the persons served, the program provides, arranges for, or assists with arrangements for the following services:
   a. Health-related services:
      (1) Nutrition.
      (2) Medical care.
(3) Health promotion.
(4) Home health.
(5) Dental care.
(6) Nursing services.
(7) Mental health.
b. Rehabilitation services:
   (1) Physical therapy.
   (2) Occupational therapy.
   (3) Speech therapy.
   (4) Creative arts therapy.
   (5) Therapeutic recreation.
   (6) Assistive technology.
c. Social services:
   (1) Counseling for the persons served.
   (2) Counseling for members of their families/support systems.
   (3) Support services.
   (4) Education on community resources.
d. Housekeeping services.
e. Laundry services.
f. Security services.
g. Transportation services.

Intent Statements
Ongoing screenings/assessments determine needs of persons served and identify services to address those needs. Based on the scope of services, the program determines how various services can be accessed by individuals.

Examples
A program may provide services through program personnel, arrange for services by contracting or making formal relationships with another company or individual to deliver services, or assist with arrangements such as scheduling appointments and providing transportation to providers in the community.
Arrangements are made by the program for persons served to have their hearing and vision tested during program hours by visiting professionals.
The program may offer regular classes for the persons served on prevention and wellness, holistic approaches to managing their health, and dealing with life transitions. The classes may be taught by faculty from the local community college and are open to members of the community in addition to persons served and personnel.
A person served desires to visit the family dentist in the dental office. Personnel assist the person served to make the appointment and arrange transportation to the dentist’s office.
A person served has been a member of Alcoholics Anonymous (AA) and may desire to continue participation. An invitation is made to the AA group to meet at the program, or arrangements are made for one of the members to transport the person served to the meeting. A companion may be required, and these arrangements are made.
The spouse of a person served with Alzheimer’s disease may be having a difficult time adjusting to the changes. The program provides information about the local chapter of the Alzheimer’s Association.
Creative arts therapy could include art therapy, music therapy or dance therapy. In general, these are services provided by personnel who have received training in utilizing these forms of creative art to address physical, emotional, cognitive and social needs of individuals of all ages.
A person served may desire to have certain articles of clothing dry cleaned. Arrangements may be made to have the clothes picked up by a dry cleaner and delivered back to the person served.

Resources
- American Art Therapy Association: www.arttherapy.org
- American Music Therapy Association: www.musictherapy.org
- American Dance Therapy Association: www.adta.org
- The Canadian Art Therapy Association: www.catainfo.ca
4. The program provides or arranges for physician input, as appropriate, regarding:
   a. The adequacy of individual health services.
   b. Transition decisions for the persons served.

Examples
Physician input may be sought from a medical director, physician who participates on a care planning committee, utilization review committee, or admissions/transitions committee.
A physician's assistant or nurse practitioner functioning as an extender of a physician may also provide input.
A physician might provide consultation for specific treatment such as wound care, diabetic foot care, significant weight loss or gain, cognitive impairments, or psychological issues.

5. The program:
   a. Provides education, if needed, regarding end-of-life choices.
   b. Honors the person's choices concerning end of life.
   c. Initiates related services when appropriate.
   d. Gives opportunities for expression of final choices concerning end of life to:
      (1) The persons served.
      (2) Families/support systems.
   e. Provides opportunities to express grief and loss.

Examples
Persons served may be interviewed about preferences regarding end-of-life (i.e., music, people, preparation and notification, comfort items, spiritual needs); person-centered planning includes these preferences.
Information regarding advance directives may be kept in an accessible location in a residential unit of the program.
Annually during the month of their birthday, persons served might have a physical exam from their primary care physician and meet with clinic staff to perform a medication review and update contact information and advance directives.

Resources
- National Coalition for Hospice and Palliative Care:
  www.nationalcoalitionhpc.org/ncp

6. When the program provides medication management/assistance, the organization establishes a relationship with a pharmacist for persons served:
   a. To advise on an ongoing basis about medication management/assistance, including:
      (1) Policies and procedures that address medication management/assistance.
      (2) Actions to take in case of an emergency.
      (3) Administration/assistance.
      (4) Dispensing.
      (5) Disposal.
      (6) Documentation.
      (7) Errors.
      (8) Implications for management of multiple medications.
      (9) Implications of abrupt discontinuation.
      (10) Indications and contraindications.
      (11) Obtaining medication.
      (12) Procedures for handling controlled substances.
      (13) Side effects.
      (14) Storage.
   b. To conduct drug regimen reviews for the persons served.

Intent Statements
A pharmacist consults with the program at a timeframe consistent with law and regulation in order to advise on medication management/assistance. This standard applies to all components of the program where medication management/assistance is provided. Ongoing communication with a professional helps to reduce medication errors for the persons served.
Examples

- The program schedules time in the meeting room quarterly for a pharmacist to meet with residents who receive medication management/assistance. Residents are encouraged to bring their medications, ask questions and obtain information.
- A consultant pharmacist visits the assisted living or nursing care each month to provide guidance and conduct drug regime reviews for residents. Reports from the consulting pharmacist are reviewed by appropriate managers and provided to each of the prescribing physicians for review.
- A resident who is terminally ill is not experiencing adequate pain control. Personnel meet with the pharmacist who makes recommendations to the physician for better pain management.
- Persons served on the dementia unit are often groggy during breakfast. The pharmacist reviews the medications given to these persons served and suggests changes in dosage and frequency of administration.
- The pharmacists identifies persons served who need lab work done and this information is shared with nursing and medical personnel.
- When persons served are required to comply with medication formularies, the consultant pharmacist assists by suggesting alternative medications.

2.B. 7. The program provides information on persons served contracting for outside services, including:
   a. Exploring services.
   b. Hiring services.
   c. Managing services.
   d. Information exchange with program personnel.
   e. Terminating services.

Intent Statements

When persons served hire their own services such as personal care attendants, companions, drivers, pet care, or other types of services, clarity regarding how such services are to be initiated, managed, and ended are important to manage risk for all parties.

2.B. 8. Policies addressing the following are implemented:
   a. Requirements for services arranged by the person served.
   b. Pets.
   c. Service animals.
   d. Upkeep and maintenance of individual residences.
   e. Smoking.
   f. Guests.

Examples

8.b. A policy regarding pets may address:

- Persons served who desire to have their pets live with them in the program may be allowed to do so.
- When the program invites family members and/or volunteers to bring pets for persons served to enjoy.
- Responsibilities for pet care, including feeding, walking, vaccinations, and vet care.
- The options available when persons served need assistance fulfilling pet-related responsibilities.

2.B. 9. The program provides, arranges or assists with arrangements for transportation services, including necessary assistance, for all persons served to participate in:
   a. Appointments.
   b. External community events.
   c. Outings sponsored by the program.
   d. Recreational and leisure opportunities.
   e. Religious services.
   f. Shopping.
2.B. 10. Policies and written procedures allow the opportunity for the persons served to receive visitors 24 hours a day, if desired and the visit does not infringe upon the health, safety, or rights of any persons served.

2.B. 11. When available, persons served residing in assisted living or nursing care may choose to:
   a. Have a private or semiprivate living unit.
   b. Have roommates.

Intent Statements
Persons served consider choice regarding living arrangements a key element of quality. Over time, person served preferences may change and should be respected by the program to the extent possible given the physical plant.

Examples
A couple that desires to live together may share a room.
After living in the program for several months, two persons served decide they would like to be roommates. Personnel assist them in making the necessary room changes when a room becomes available.
The program has a limited number of private rooms, but maintains a wait list for persons served who desire to be in a private room.
During the initial visit to the program, the person served is shown all available rooms and chooses their room.
An individual’s roommate moves out of the program. The person served indicates he would like to move to the other side of the room and personnel assist with the move.

2.B. 12. Individual units provide for:
   a. Personal choice about:
      (1) Possessions.
      (2) Décor.
   b. Accessibility.
   c. Healthcare needs of the persons served.
   d. Personal security.
   e. Privacy.
   f. Safety.
   g. Security of personal possessions.

Intent Statements
Home is a place where persons served are safe and their possessions are secure and accessible. The environment reflects their preferences, supports independence, and meets their needs.

Examples
12.a. Individual units may be decorated with different color schemes and contain personal possessions such as furniture, paintings, photographs, and linens.
The person served may have a grandfather clock or other large piece of furniture or artwork that cannot fit in their individual unit but, with permission of the person served, may be displayed in a common area.
12.b. Adaptations might be made in individual units including closets, and bathrooms to facilitate independence in self-care and attending to persons served health needs.
A clothes bar may be lowered for an individual who uses a wheelchair.
12.e. Privacy might include accommodations for individuals to have confidential conversations or to have intimate interactions.
12.g. The program may provide a place for persons served to secure their valuables.

2.B. 13. The program:
   a. Equips each individual unit with an emergency call or monitoring system.
   b. Implements a system to summon emergency backup when needed.

Intent Statements
When maintaining an emergency monitoring system, providers should refer to Standard 1.H.3. to ensure that persons served are educated on use of the system, and to Standard 1.H.14. to verify, through the self-inspections process required in Standard 1.H.14., that the system is in working order.
Examples
In individual units, apartments, cottages, or other personal living spaces, this may be a pull cord system, pendant, or a system in which a phone that is knocked off the hook automatically alerts a call center.

Emergency backup may be to direct persons served or personnel to call 911 or call the operator.

2.B. 14. The program implements safety and security measures, including, but not limited to:
   a. Surveillance.
   b. Entry to and exit from the property.
   c. Entry to and exit from individual units.
   d. What to do in case of an emergency.
   e. Personal security options.

Intent Statements
This standard is focused on approaches, ways, or methods that the safety of the persons served, personnel, and other stakeholders are maintained on the premises of the organization. This includes the general campus or building, individual units, and measures that may be used by individuals. This is not a standard about data measures, but rather about how the organization describes techniques and approaches implemented to foster a safe environment.

Examples
14.a. Surveillance may include personnel who regularly or periodically check-in on persons served. It might also include cameras in areas such as parking lots, stairwells, and other parts of the physical plant. Because organizations have varying budgets and population needs, the term “surveillance” can mean people who do a walkthrough of the physical plant, or it can mean an electronic system.

14.b. Measures that address entry and exit could include a gated community where individuals have to be buzzed in or use an access code to enter the property. Entry and exit might also be tracked by having visitors sign in at the front desk before visiting the person served.

14.c. Safety and security measures for individual units might include a locked door with a peep-hole or a door bell.

14.d. Measures related to what to do in case of an emergency might address how personnel are to respond if a person served or visitor is experiencing physical distress when they enter the premises. There might be specific measures to be taken if someone falls, chokes, or has some other emergency while on the premises of the organization.

14.e. Personal security options might include a person served choosing to wear a medical alert bracelet or pendant due to a particular medical need, having a personal medical monitoring device in his or her unit, having a whistle alarm or flashlight on a key chain, or other personal security devices or techniques.

2.B. 15. The organization demonstrates efforts to maintain or improve the physical environment, including:
   a. Preventive maintenance.
   b. Cleanliness.
   c. Plans for capital improvements of property.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Policies and procedures addressing how the program provides, arranges, or assists with arrangements for various categories of services
- Policies addressing persons served hiring private duty care, home care, or other assistance
- Policies on visiting hours and guests
- Policies addressing whether pets are allowed and any details on responsibilities for caring for pets
C. Care Process for Specific Diagnostic Categories

Applicable Standards
The standards in this section are applicable if the program serves any persons with dementia and is not seeking accreditation as a Dementia Care Specialty Program.

2.C. 1. To empower the persons served with dementia to make decisions each day that are consistent with their abilities, the program, on an ongoing basis:
   a. Assesses the ability of the persons served with dementia to make decisions.
   b. Minimizes barriers to decision making by the persons served with dementia.
   c. Communicates with the persons served with dementia regarding the immediate consequences associated with choices and behaviors that pose a potential risk to their health or safety.
   d. Facilitates appropriate support for decision making by the persons served with dementia.
   e. Documents significant discussions and decisions made by the persons served with dementia in their records.

Intent Statements
While complex decisions may not always be feasible, there are more simple decisions that a person served with dementia may be able to continue to make in order to maintain quality of life. The program personnel demonstrate approaches to communicating with the person served in a manner that clarifies his or her decision-making capacity because it can fluctuate over time, including at different times of the day.

Examples
1.a. Assessing the ability of the persons served to make decisions at different points in the day when they may be better able to interact with care providers may occur through careful observation, communication, and documentation to determine what cognitive patterns may be occurring.
1.e. This could include decisions that impact the person-centered plan of care, decisions that come up repeatedly, and high-level decisions. Significant discussions and decisions could also be related to nutrition, social interactions, or communications with family members. It may be important to document that discussions occurred with the person served and possibly also the nature of the discussion in order to be clear among caregivers why a specific decision was made.

2.C. 2. The ongoing screening/assessment process includes information about the person's:
   a. Life history.
   b. Important memories.
   c. Favorite stories.
   d. Daily routines.
   e. Comfort/reminiscence objects.
   f. People of importance.

Intent Statements
This standard supplements Standard 2.A.13. on initial and ongoing written screenings/assessments of the persons served. By using a person-centered approach to screening/assessment the program gains an understanding of the person living with dementia, including his or her values, beliefs, interests, abilities, likes and dislikes, etc., and uses this information to inform the person-centered plan addressed in Standard 2.A.14. As a person's dementia progresses, an ongoing process for screening/assessment provides information on changing needs and preferences.

Examples
2.a. Life history may be gathered over time through a variety of techniques, including guided questions during a one-on-one conversation;
observation; and information taken from group activities using photographs, music, food, or other items that might spark conversation. Information gathered might include accomplishments, losses, significant experiences, hopes, dreams, preferences, important roles, and ways of dealing with previous challenges or stressful situations. Understanding the whole person in this way provides greater understanding and appreciation of the person served and his or her life experiences and promotes dignity and respect.

2.f. People of importance may include extended family such as nieces, nephews, grandchildren, and others such as friends, neighbors, and individuals from the person’s spiritual community. People of importance may also include significant others/life partners as individuals may or may not wish to publicly identify as a member of the LGBTQ community.

Resources
- Person-Centered Assessment and Care Planning: https://academic.oup.com/gerontologist/article/58/suppl_1/S32/4816742

2.C. 3. The program provides or arranges for education:
   a. To the persons served.
   b. To families/support systems.
   c. In accordance with identified needs that addresses, but is not limited to:
      (1) Dementia, including:
          (a) Signs and symptoms.
          (b) Progression.
          (c) Types of dementia.
          (d) Coexisting conditions.
          (e) Lived experience of dementia.
      (2) Maintaining relationships.
      (3) Skills training, including:
          (a) Activities.
          (b) Therapeutic approach to behavior.
      (c) Communication skills, including communication with:
          (i) Persons served.
          (ii) Service providers.
      (d) Caregiver self-care.
      (4) Coping with changes.
      (5) Driving.
      (6) Falls.
      (7) Incontinence.
      (8) Loss and grief.
      (9) Legal issues.
      (10) Mobility.
      (11) Palliative care.
      (12) Planning for the future.
      (13) Risk of elopement.
      (14) Sexuality.
      (15) Skin integrity.
      (16) Community resources.
      (17) Payer sources.

Examples
3.b. Education is important to assist the family/support system in its understanding of the evolving needs of a person with dementia and to address concerns related to the role of being a caregiver.
3.c.(1)(e) “Lived” experience may refer to gaining a better understanding of how an individual with dementia might be perceiving his or her surroundings and interactions with others as dementia progresses.
3.c.(3)(d) Examples of caregiver self-care may include counseling for caregiver stress reduction, online support groups to share experiences and gain insights, techniques for caregiver wellness and nutrition, respite care options, and other resources that may assist the caregiver to manage physical and mental fatigue as well as grief.
3.c.(5) Education related to driving may include identifying whether a person served is able to drive safely and awareness of how to access local resources for individuals who no longer drive, including volunteer driver programs and various forms of public transportation such as paratransit and other services.
3.c.(9) Legal issues may include education and information for persons served and their families/support systems for drafting and maintaining advance directives, do not resuscitate (DNR) orders, and powers of attorney so that the representative of the person served may facilitate service delivery in a way that reflects the wishes of the person served.

3.c.(16) Community resources might include respite care, volunteer drivers, friendly visitor programs, and pet therapy programs.

3.c.(17) Persons served and their families/support systems may not have knowledge of funding sources for various services, so the program might link individuals with local, state/provincial, or national information resources to help navigate the various funding sources for services, equipment, and specific types of care.

Resources

Resources for dementia care programs include:

- The Alzheimer Society of Canada provides information, resources, education, support, and counseling for individuals impacted by dementia: www.alzheimer.ca
- WorkSafe BC offers a publication titled *Dementia: Understanding risks and preventing violence*: www.worksafebcmedia.com/media/WebBooks/Dementia/index.html#welcome
- The Canadian Institute for Health Information has taken a comprehensive look at dementia in Canada and has compiled a variety of information on the complex illness and the impact on seniors, caregivers and health systems: www.cihi.ca/en/dementia-in-canada

3.b. A number of caregiver organizations offer numerous dementia-related training resources and educational materials, including:

- The National Alliance for Caregiving: www.caregiving.org
- International Alliance of Carer Organizations: https://internationalcarers.org
- Family Caregiver Alliance: www.caregiver.org
- Caregiver Action Network: www.caregiveraction.org
- Safety in Dementia: https://safetyindementia.org

3.c.(5) Various organizations offer assessment tools that may help with assessing individuals’ driving ability, including:

- http://seniordriving.aaa.com/evaluate-your-driving-ability
- www.aarp.org/auto/driver-safety/driving-tips/

3.c.(6) The following resources may be useful in addressing falls:

- The World Health Organization: www.who.int/ageing/publications/Falls_prevention7March.pdf
- Ontario Osteoporosis Strategy: www.osteostategy.on.ca
- National Falls Prevention Resource Center: www.ncoa.org/healthy-aging/falls-prevention/

The following resource may be useful in addressing palliative care:

- Health Quality Ontario and the Ontario Palliative Care Network: www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Palliative-Care
2.C. 4. Personnel implement a positive, therapeutic approach to behavior.

Intent Statements

Responsive behaviors is a term that is used to describe the behaviors of people with dementia, such as agitation, wandering, or depression. The term shows how the actions, words, and gestures of people with dementia are a response to their current environment. When trying to understand the behaviors of a person served, it is important to employ a positive, therapeutic approach to respond to words, gestures, and actions that the person makes to communicate meanings, needs, and concerns. Positive therapeutic approaches are typically multidisciplinary and consider the following:

- What external factors may be influencing the behavior?
- Is the behavior a problem for the person served or for me?
- Will the “solution” cause more anxiety than the problem?

Ultimately, because a person with dementia cannot be expected to change, the idea is to accept the individual as he or she is in this moment.

Resources

Resources to assist with therapeutic approaches to behavior may include:

- Alzheimer Society Canada: www.alzheimer.ca
- Helpguide.org: www.helpguide.org/articles/alzheimers-dementia/alzheimers-behavior-management.htm

2.C. 5. As appropriate, the program incorporates into the person-centered plan:

a. A palliative approach to care.
b. End-of-life care.

Intent Statements

Persons served, families/support systems, and personnel have opportunities to discuss end-of-life issues and participate in planning remembrance or memorial activities and creating end-of-life protocols.

Examples

Families/support systems should be involved in the development of advance directives and in identifying the extent to which medical intervention is to be administered.

Whenever possible, no one dies alone. Support and presence is planned for each person served so that he or she does not die alone.

The person served and his or her family/support system are interviewed about preferences for the dying process (e.g., five wishes, music, individuals present, preparation and notification, comfort items, and spiritual needs); care planning includes these preferences.

Memorial gardens may be developed outside on organization property in remembrance of those lost.

Memorials that reflect the person may be evident throughout the organization.

Do not resuscitate (DNR) orders are known and strictly adhered to. Efforts are made to clarify issues related to a person's end-of-life wishes to avoid any misunderstanding on the part of personnel and/or the family/support system.

Some organizations do not choose to have a memorial service, but they may provide opportunities for personnel to express their grief by supporting them so they may attend the funeral of a person served.

Resources

- Forget Me Not: Palliative Care for People with Dementia: www.ncbi.nlm.nih.gov/pmc/articles/PMC2600060
- Your Conversation Starter Kit for Families and Loved Ones of People with Alzheimer’s Disease or Other Forms of Dementia: https://theconversationproject.org/wp-content/uploads/2017/02/ConversationProject-StarterKit-Alzheimers-English.pdf
2.C. 6. If the program utilizes volunteers, it provides documented, competency-based training to volunteers that addresses:
   a. Communication.
   b. Dementia.
   c. Post-incident debriefing opportunities.
   d. Therapeutic approach to behavior.

Intent Statements
Although volunteers can be valuable to a program, it is important to have those individuals who interact with persons served and who impact service delivery receive competency-based training. This standard would not include a volunteer who assists with projects such as letter-stuffing for a one-time fundraising event.

Examples
Volunteers who assist with outings might receive training on emergency procedures, communication approaches, and how to maintain safety of individuals.

6.c. When incidents involving a person served occur during the volunteer engagement, the organization may find it helpful to debrief with the volunteer following an incident such as a person served beginning to cry during an art activity and/or yelling for help. Debriefs might be in a quiet location, shortly after the incident, and may provide an opportunity to explain potential causes, strategies that worked and did not work, and how to manage the stress or other emotions that may have resulted from the incident.

6.d. Volunteers might receive competency-based training regarding sexuality topics that are important to understand and respond to therapeutically if behaviors are exhibited by persons served.

2.C. 7. The organization provides documented competency-based training for personnel, as appropriate to their roles:
   a. At:
      (1) Orientation.
      (2) Regular intervals.
   b. That includes:
      (1) Dementia, including:
          (a) Signs and symptoms.
          (b) Progression.
          (c) Types of dementia.
          (d) Coexisting conditions.
          (e) Lived experience of dementia.
      (2) Delirium.
      (3) Depression.
      (4) Suicide risk assessment and prevention strategies.
      (5) Identifying the personal preferences of the persons served.
      (6) Loss and grief.
      (7) Communication.
      (8) Therapeutic approach to behavior.
      (9) Observation skills.
      (10) Sexuality.
      (11) Skin integrity.
      (12) Meaningful engagement of persons served on an ongoing basis.
      (13) Therapeutic approach to activity development and implementation.
      (14) Gathering information about the person served in the following areas:
          (a) Life history.
          (b) Important memories.
          (c) Favorite stories.
          (d) Daily routines.
          (e) Comfort/reminiscence objects.
          (f) People of importance.
Intent Statements

7.b.(12) Almost every interaction in daily routines offers opportunities for meaningful engagement and activity-based care. Personnel are trained to actively seek opportunities, both planned and spontaneous, to engage in meaningful and purposeful interaction with the persons served.

Examples

7.b.(4) Identifying persons served in distress or exhibiting self-injurious behavior is part of ensuring that individuals receive the care and support needed to prevent suicide. Approaches might include teaching personnel about warning signs, screening protocols, and care approaches including assessing the environment to reduce access to means like balconies or windows.

7.b.(13) Therapeutic service delivery approaches might integrate favorite music, favorite foods, and other types of sensory engagement.

7.b.(14) Gathering information about the person served as part of the screening/assessment process may be enhanced by other conversation and observation approaches that may also be necessary to gather and maintain current information in light of frequent changes with the person served. It may be useful to have competency-based training focused on behavior versus asking questions about each area. Gathering information using various approaches may be useful to understand the current reality of the person served along with his or her communication level.

Practices might include observing and interpreting the meaning of behaviors and key words, phrases, or sounds used by the person served and what they indicate about the person. Strategies for understanding and responding to the information shared by the person served may include validation, mirroring, distraction, redirection, and cueing.

Resources

- Mayo Clinic: www.mayoclinic.org/healthy-living/caregivers/in-depth/alzheimers-caregiver/art-20047577
- Canadian Alzheimer’s Association: www.alz.org/ca/what-we-do-canada.asp
- Canadian Hospice and Palliative Care Association: www.chpca.net
- Alzheimer Society of Toronto has a Personal Support Worker Community: www.alzheimertoronto.org

The Alzheimer’s Association Curriculum Review and essentiaALZ certification: www.alz.org/professionals/professional-providers/dementia-care-training-certification
D. Skin Integrity and Wound Care Standards

Applicable Standards
The standards in this section apply to:
- Section 3.B. Assisted Living
- Section 3.C. Person-Centered Long-Term Care Community
- Section 3.D. Home and Community Services, if Standards 3.D.16.–18. apply (i.e., if specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need are provided)
- Section 3.G. Continuing Care Retirement Community (assisted living and nursing care levels of the CCRC only)

2.D. 1. The program implements written procedures to address skin integrity and wound care, including:
   a. Initial and ongoing assessments of skin integrity.
   b. Management of skin integrity issues.
   c. Definition of what constitutes a wound.
   d. Wound care.
   e. Procedures for referral if assessment or management is outside the scope of the program.

2.D. 2. Initial and ongoing assessments of each person served document information about:
   a. Skin integrity, including:
      (1) Edema.
      (2) Pain.
      (3) Pulses.
      (4) Skin appearance.
      (5) Skin turgor.
   b. Risks to skin integrity.
   c. Results of previous interventions, if applicable.

Intent Statements
2.c. This includes interventions implemented by the team to address current skin integrity issues as well as interventions to address previous skin integrity issues.

Examples
The frequency of reassessment may be based on the needs of individual persons served, the program’s written protocols, evidence-based practices, in accordance with regulatory requirements, or other considerations.
2.a. Assessments may be head to toe, e.g., if someone is diabetic, or focus on a body area, e.g., a person served who is wearing a splint following a wrist injury.
2.a.(5) Skin turgor refers to the elasticity of the skin and may indicate dehydration in the person served.

2.D. 3. When skin integrity risks are identified through the assessment of the person served, the interdisciplinary team:
   a. Addresses identified needs that are within the scope of the program, including:
      (1) Interventions to prevent or reduce the risk of a wound developing.
      (2) Standards of practice.
      (3) Nutritional needs.
      (4) Equipment.
      (5) Supplies.
      (6) Education needs of:
         (a) The person served.
         (b) The family/support system.
         (c) Personnel.
   b. Refers the person served to an appropriate healthcare professional to address identified needs that are outside the scope of program.

Intent Statements
Measures to address the skin integrity risks of the person served are intended to prevent a wound from developing.
Examples

Evidence of the team addressing the skin integrity needs of the person served may be found in the individual plan of the person served; team or family conference summaries; and equipment, supply, or medication orders. The way that the team addresses the skin integrity needs should be aligned with the scope of the program, meaning that some teams may address the needs directly, other teams may make referrals to clinicians, or there may be a combination of approaches depending on the skin integrity need.

3.a.(4) Equipment may include orthotics, prosthetics, seating cushions and supports, bed support surfaces, and wheelchairs.

2.D. 4. If a wound is present, the interdisciplinary team for each person served implements written protocols that address:

a. When the wound care needed is within the scope of the program:
   (1) Documented initial and ongoing assessments of wounds, including:
      (a) Location.
      (b) Description of base.
      (c) Measurement.
      (d) Exudates.
      (e) Progression.
      (f) Causes.
   (2) Interventions to reduce and/or eliminate the wound.
   (3) Standards of practice.
   (4) Nutritional needs.
   (5) Equipment.
   (6) Supplies.
   (7) Education needs of:
      (a) The person served.
      (b) The family/support system.
      (c) Personnel.
   (8) A plan for follow-up care.

b. When the wound care needed is outside of the scope of the program, referrals to or coordination with appropriate wound care specialists.

Examples

4.a.(1) This includes surgical and nonsurgical wounds, pressure sores, and other types of sores from injuries or other causes.
4.a.(1)(d) An exudate is any fluid that filters from the circulatory system into lesions or areas of inflammation. It can be a pus-like or clear fluid.
4.a.(1)(e) Progression may include staging of a pressure sore.
4.a.(1)(f) Causes of wounds may include infection; hematoma; co-morbid conditions such as diabetes or vascular disease; immobility; poor sensation; and external factors such as pressure, sheer, puncture, laceration or blunt force.
4.a.(2) Interventions may include, but are not limited to, the use of medications, recommendations for surgery, topical treatment, lifestyle change, shoe adaptation, seating and positioning, infection management, and the use of modalities such as negative pressure wound therapy.

2.D. 5. The program identifies and utilizes local, regional, provincial, national, or international resources to facilitate wound care.

2.D. 6. The interdisciplinary team demonstrates efforts to optimize outcomes for the persons served, including, but not limited to:

a. Exchange of information on factors facilitating skin integrity and wound management.
b. Exchange of information on barriers to skin integrity and wound management.
c. Education of other healthcare providers.
d. Collaboration with other healthcare providers on the timing of interventions.
e. Arrangement of follow-up with other healthcare providers at the time of discharge/transition from
the program to facilitate ongoing assessment and management of skin integrity and wound issues.

Examples
6.d. Collaboration may be among providers on the program’s service delivery team and with consulting, concurrent, or follow-up providers.

2.D. 7. Personnel who provide services related to skin integrity and wound management receive documented, competency-based training:
   a. At:
      (1) Orientation.
      (2) Regular intervals.
   b. That includes, but is not limited to:
      (1) Assessment protocols for skin integrity and wound management.
      (2) Strategies and interventions for skin integrity and wound management that are based on accepted practices in the field and current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.
      (3) Education techniques to facilitate behavior change in persons served.

Examples
7.b.(2) This may include the use of evidence-based wound products and supplies.

2.D. 8. The program:
   a. Gathers information on each person served, including information on:
      (1) Wounds present at admission to the program that improved during the program.
      (2) Wounds present at admission to the program that worsened during the program.
      (3) New wounds that developed during the program.
   b. At least annually conducts a written analysis that includes:
      (1) Performance in relationship to established targets for:
          (a) Wounds present at admission to the program that improved during the program.
          (b) Wounds present at admission to the program that worsened during the program.
          (c) New wounds that developed during the program.
      (2) Trends.
      (3) Actions for improvement.
      (4) Results of performance improvement plans.
      (5) Necessary education and training of:
          (a) Persons served.
          (b) Families/support systems.
          (c) Personnel.

Intent Statements
This standard relates to the standards in Sections 1.M. Performance Measurement and Management and 1.N. Performance Improvement. In order to analyze performance it is expected that the program identifies objectives, performance indicators, and performance targets for 8.b.(1)(a)–(c).
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Documentation of initial and ongoing assessments that address skin integrity
- Written protocols for wound care needs, including needs that are within the scope of the program and needs outside the scope of the program
- Information on local, regional, provincial, national, or international resources used to facilitate wound care
- Documentation of competency-based training for personnel who provide services related to skin integrity and wound management
- Written analysis of information gathered on persons served regarding wounds present at admission to the program that improved and worsened during the program, and new wounds that developed during the program
SECTION 3

Program Specific Standards

A. Adult Day Services

Description
An adult day services program is a nonresidential program that provides supervised care to adults of all ages in a supportive and safe setting during part of a day. Assessments of the persons served and their families/support systems and person-centered plans of care drive the delivery of services. An adult day services program provides or arranges for services that include, but are not limited to, therapeutic activities, nutrition, health and personal care, and transportation.

Adult day services programs typically deliver services through a social model and/or a medical model. Either of these might provide services to specialized populations of persons served. By supporting family systems, an adult day services program enables the persons served to live and engage in the community and provides the family system with an opportunity to fulfill daily responsibilities and for respite. An adult day services program strives to optimize the dignity, choice, preferences, autonomy, and quality of life of the persons served.

Applicable Standards
An organization seeking accreditation for an Adult Day Service program must meet the following standards:
- All standards in Section 1.
- All standards in Section 2.A.
- Standards in Section 2.C., as applicable.
- All standards in this Section 3.A.

3.A. 1. If the adult day services program is co-located in an organization housing other services, the adult day services program will have during its operational hours separate designated space.

Examples
A residential program also operates an ADS program three days a week for community participants. On the days the ADS program is operated, the activity space is only used for persons attending the ADS program and guests of program participants.

3.A. 2. The program’s role in and use of a continuum of care that is responsive to the needs of the persons served are:
   a. Demonstrated.
   b. Documented.
   c. Utilized in establishing linkages with community agencies/institutions for coordination of services.

Intent Statements
Programs providing adult day services recognize that they are part of a larger network of available services within the community it serves. Adult day service providers have strategies for maintaining their connection with other parts of the continuum.

Examples
Programs may have a relationship with a case management group, or hospital or clinics in the area that refer individuals to the program. The program might also have relationships with other providers such as outpatient facilities, home care, transportation, companion services, retirement communities, assisted living and nursing centers to which it refers persons served. Relationships could be documented through philosophy statements, referral agreements,
community collaborative agreements, community-wide health projects and documentation indicating participating in a local networking alliance.

3.A. 3. Documented unit cost data:
   a. Are calculated at least annually as part of the budgeting process.
   b. Allow for comparative analysis.
   c. Are shared with relevant stakeholders.
   d. Are used for business/strategic planning.

Intent Statements
By understanding the actual cost per client day, a program is better prepared to conduct strategic planning, budget process, contract negotiations, and advocacy efforts.

Examples
Sample Calculation:
   Number of Days Open ......................... 250
   Average Daily Census ......................... 14
   Total Budget ....................................... $160,000
   Total Budget ÷ Number of Days Open
   × Average Daily Census = Unit Cost
   $160,000 ÷ [250 x 14] = $45.71

An example of how an ADS program may use this information for planning might include examining the difference between reimbursements compared to the actual cost of providing services.

A program calculates unit cost per client day. The Medicaid contract pays less than the unit cost. The program uses this information to identify the amount of supplemental income needed to cover its costs. The program may also share this information with state legislatures to advocate for increased reimbursement.

3.A. 4. To ensure that the family/support system is involved as desired by the person served, the program provides, arranges, or assists with arrangements for services for each family/support system, as needed, including:
   a. Advocacy education.
   b. Assistive technology.
   c. Counseling/support services.
   d. Education.
   e. Reasonable accommodations.
   f. Respite.
   g. Support.

Intent Statements
The program recognizes that the family/support system is essential to enabling persons served to live in the community.

Examples
Services for family/support systems may be in areas of:
- Assistance with activities of daily living such as bathing.
- Education related to the use of communication boards with a person served who can no longer speak following a stroke.
- Education about managing specific conditions such as high blood pressure, diabetes, cholesterol, and/or dementia may be provided as appropriate.
- Resources to support those with visual or hearing impairment.

3.A. 5. Based on need, the program makes current information available:
   a. To the persons served.
   b. To families/support systems.
   c. Regarding:
      (1) Adult protective services.
      (2) Alternative housing.
      (3) Care management services.
      (4) Community service organizations.
      (5) Crisis intervention programs.
      (6) In-home services, including:
          (a) Home healthcare services.
          (b) Homemaker services.
      (7) Meal delivery services.
Section 3.A. Adult Day Services

(8) Specialized services unique to the population served.
(9) Transportation options.
(10) Wellness and health promotion.
(11) Other services, as needed or required.

Intent Statements

The program is aware of resources available in the community that may assist persons served and their families/support systems.

Examples

Programs may maintain a resource library, offer participant/family education, host family council meetings, conduct town hall meetings, post information on bulletin boards or in newsletters and/or make referrals to local agencies.

5.c.(4) Support groups.
5.c.(6)(a) Home healthcare could include in-home services by healthcare professionals, such as nurses or therapists.
5.c.(6)(b) Homemaker services could include light housekeeping, meal preparation, shopping or companion services.
5.c.(8) Mental health, Alzheimer's Association, home safety evaluations, pharmacy delivery, home modification companies.
5.c.(11) Hospice, durable medical equipment, hearing aids.

3.A. 6. The program communicates information regarding medication given during program hours:

a. To:
   (1) The persons served.
   (2) Their families/support systems.

b. That addresses:
   (1) Actions to take in case of an emergency.
   (2) Administration/assistance.
   (3) Dispensing.
   (4) Documentation.
   (5) Errors.
   (6) Identification of medication, including why each medication is given.

(7) Implications of abrupt discontinuation.
(8) Implications for management of multiple medications.
(9) Indications and contraindications.
(10) Procedures for handling controlled substances.
(11) Side effects.
(12) Storage.

3.A. 7. Current emergency information is available in writing for each person served that includes the person's:

a. Advance directives.
b. Allergies.
c. Behavioral symptoms.
d. Cognitive status.
e. Current diagnoses/conditions and history.
f. Emergency contact information.
g. Equipment and devices.
h. Functional status.
i. Hospital preference.
j. Healthcare providers involved in care, including contact information.
k. Immunization status.
l. Insurance information.
m. Medications.
n. Mental health status.
o. Photograph (for identification of the person served).
p. Prosthetics and orthotics information.
q. Risk factors.
r. Vision and hearing.

Intent Statements

Information that is portable is important in emergency situations. The way this information is maintained can vary between organizations.

Examples

Adult day personnel may have a list of available phone numbers for alternative transportation.
when a participant’s regular transportation is not available.

7.c. Behavioral symptoms may include a diabetic who articulates that when their blood sugars get low they respond in an aggressive manner. A daughter may inform the program personnel that when her mother becomes frustrated with an activity she begins to pace. This information is helpful to personnel so that they may respond appropriately to emergencies.

Depending on the size of the records and the number of persons served, assisted living and nursing home may want to use the entire record of the person served as the emergency information file.

Files may be saved on a flash drive and kept on a key ring.

Files may be computer files.

B. Assisted Living

Description

Assisted living is a residential program that provides meals, housing, and a range of hospitality and personal care services for adults of all ages in a supportive and safe home-like setting. Assisted living strives to optimize the dignity, choice, preferences, autonomy, engagement in life roles, and quality of life of the persons served. The program might provide services for specialized populations of persons served.

Assisted living offers a culture of customer service and hospitality as well as an environment of safety and security for persons served. A philosophy of independence, engagement, and wellness guides the communications between personnel and persons served in assisted living.

Assessments of the persons served and their person-centered plans drive service delivery. Coordination of care and care delivery are conducted in accordance with applicable regulations for the assisted living program. Staffing is provided 24 hours a day, 7 days a week. A variety of services ranging from minimal to intensive assistance with activities of daily living such as bathing, dressing, eating, grooming, mobility, toileting, and assistance with medications may be available, as well as referrals to external services. Assisted living programs may provide some health services and intermittent nursing care. Additionally, these programs may offer housekeeping, laundry services, medication management, recreation programs, and transportation.

Assisted living programs are provided in a variety of settings from a small home with just a few individuals to a high-rise building housing many individuals. Individual living accommodations can be private or shared and include a single room or a full size apartment. Assisted living may have different names in different jurisdictions.
Applicable Standards

An organization seeking accreditation for an Assisted Living program must meet the following standards:

- All standards in Section 1.
- All standards in Section 2.A.
- All standards in Section 2.B.
- Standards in Section 2.C., as applicable.
- All standards in Section 2.D.
- All standards in this Section 3.B.

3.B. 1. To help stakeholders determine whether, related to its scope of services, the program will meet the needs of the person served, the program documents information about the characteristics of the population it can effectively serve, including:
   a. Ages.
   b. Activity limitations.
   c. Behavioral status.
   d. Cultural needs.
   e. Medical conditions.
   f. Participation restrictions.
   g. Psychological status.

3.B. 2. The program demonstrates the involvement of the following individuals in the person-centered plans of the persons served:
   a. The person served.
   b. Treating physicians.
   c. Healthcare professionals.
   d. Members of the family/support system, as appropriate.
   e. Other stakeholders, as appropriate.

Examples

In order to develop an integrated plan for the person served, the groups identified may be involved based on the choice of the person served. Involvement of physicians may mean that they are consulted by phone or in a meeting to provide important information to inform person-centered planning. Other professionals such as nutritionists or therapists may also be involved in planning meetings or they may be consulted for key information related to their work with the person served.

3.B. 3. The program addresses coordination of services for spouses/significant others, when appropriate.

Examples

Services for spouses/significant others recognize the importance of these individuals in the life of the person served. Such services are directed toward spouses/significant others who are also being served in the program at another level of care or at the same level of care and could include opportunities for spouses to attend social events or trips along with the person served. They may also include opportunities for both parties to dine together regularly, to participate in person-centered planning discussions, or to have private space for personal communication.

3.B. 4. The rhythm of daily life is directed by each person served, as demonstrated by:
   a. Freedom to make choices regarding the cycle of each day, including:
      (1) Bathing.
      (2) Dressing.
      (3) Eating.
      (4) Hygiene.
      (5) Oral care.
      (6) Sleeping.
      (7) Waking.
   b. Choice of clothing.
   c. Choice of grooming style.
   d. Each person’s choice to participate in personally meaningful customary routines, including, but not limited to:
      (1) Cleaning.
      (2) Community activities.
      (3) Contact with pets.
      (4) Cooking.
      (5) Exercise/mobility activities.
(6) Gardening.

(7) Hobbies.

(8) Intimacy.

(9) Recreation.

(10) Social interaction.

(11) Spiritual/religious activities.

Intent Statements

Individuals in assisted living direct the rhythm of their daily life. From rising in the morning to retiring in the evening, the choice of the daily routine is determined by the person served. It is not dictated by the convenience of the personnel or by a schedule designed to create efficiency. Being able to accommodate the person’s rhythm of daily living is a hallmark of assisted living. Residents should not have to give up everything they are accustomed to when entering assisted living. Participating in the life of the community while maintaining their daily routine is crucial for their quality of life. Living in a community always includes the freedom to exercise individual rights and respect for the rights of others.

Examples

Persons served can be afforded opportunities to continue activities they enjoyed in their community as well as to pursue activities that will support their growth and development. Some examples of these might include:

- Choosing when to wake up, nap and retire.
- Choosing the schedule for completing their ADLs.
- Participating in meal preparation.
- Creating a garden of flowers or vegetables for use in the community.
- Caring for or simply enjoying the companionship of pets.
- Continuing to participate in the Rotary, League of Women Voters, church clubs, etc.
- Tutoring students in English as a second language (ESL).
- Assisting personnel with tax preparation.
- Engaging in intimacy with a spouse or significant other.
- Enjoying familiar recreational activities.
- Learning a new hobby or skill.
- Encouraging opportunities for the resident to engage in meaningful work, if desired.
- Engaging in meaningful interactions with other residents, personnel, and members of the local community.

Persons served who wish to do so can be encouraged to participate in the daily routine of their community by continuing to do the things they did at home (i.e., setting the table, dusting, doing laundry, gardening, woodworking.)

3.B. 5. The program addresses the impact of the following areas on the service delivery process for each person served:

a. Allergies.

b. Current medications, including:
   (1) Medication sensitivities and adverse reactions.
   (2) Why each medication is prescribed.
   (3) Side effects.
   (4) Drug interactions.
   (5) Implications of abrupt discontinuation of medications.
   (6) Compliance.
   (7) Schedule for taking medications.

c. The etiology and anticipated course of the illness, injury, impairment, disability, or specific age or developmental need.

d. Communication ability.

e. Fatigue.


g. Pain.

h. Risk factors.

i. Signs and symptoms of emergent medical or psychological conditions.

j. Sleep.

Intent Statements

The service delivery team should be able to describe and provide examples of how they provide services to individuals based on consideration of these areas. The service delivery team should be prepared to describe specific examples with individual persons served as well as more
global examples regarding the population they serve in the assisted living program.

Examples
5.c. If a person served has Parkinson’s disease, what is the anticipated course of this disease and how does this course impact the way the assisted living program would provide services to the individual? If the individual has congestive heart failure, the course of this condition might prompt diet, medication monitoring, medical checkups, and other areas of service delivery.

5.h. Risk factors might include the impact that poor diet and lack of physical exercise has on certain conditions. It might also include assessing distress levels that may be a contributing factor for suicide risk.

5.i. Sometimes swelling can indicate a problem such as heart, liver, or kidney disease. Skipping meals or lack of participation in activity programs can be a symptom of depression. Getting lost within the campus on a regular basis or going to the wrong apartment or unit regularly might be a sign of dementia.

3.B. 6. The program implements policies and procedures that address PRN (as needed) medications, including:
   a. Identification of need.
   b. Timely administration.
   c. Follow up on effectiveness.

Intent Statements
Policies and procedures regarding medications taken on an “as needed” basis rather than on a regular schedule help organizations more clearly implement appropriate practices to identify when the medications should be given so that persons served may benefit from these medications.

3.B. 7. In collaboration with the person served, the team assesses options for:
   a. Medication storage.
   b. Medication administration.
   c. Timing of administration.
   d. Location of administration.
   e. Self-administration.

f. Over-the-counter medications.
g. Complementary health approaches.

Intent Statements
Within applicable law and regulation, persons served participate with personnel in decisions about self-medication including medication storage, timing, and location. Persons served wishing to continue their use of over-the-counter medications and herbal remedies are given the opportunity to do so after it has been determined it will not negatively affect prescribed medications.

Examples
7.f. Over-the-counter medications may include a daily dose of aspirin; supplements such as fish oil, lemon balm, echinacea; and vitamins such as vitamin C, calcium, or others in doses that can be purchased at a grocer.

7.g. Complementary health approaches may include the use of herbal remedies, essential oils, complementary therapies, and cultural practices. The use of complementary health approaches may be addressed between the person served and his or her physician. The program does not need to offer or provide complementary approaches; however, if the person served pursues such options, the program may work with the person to determine options for these approaches within the program.

3.B. 8. As indicated by the person-centered plan, the program implements a process for scheduled safety checks of the persons served.

Intent Statements
Person-centered plans should identify service needs and necessary supports for persons served so that scheduled safety checks are used when needed for individuals. To this end, scheduled safety checks are implemented so that organizations may keep a “watchful eye” on behalf of persons served while continuing to respect their privacy and self-determination.

Examples
Visits to persons served might occur if they miss one or more scheduled meal times that they generally attend.
If a person does not return home from an appointment or other outing when scheduled to do so, personnel may stop by the individual’s unit to make sure everything is all right.

3.B. 9. Upon request, the program provides nutritional information about items on its menu.

Intent Statements
To ensure that persons served who have specific dietary restrictions or needs are able to obtain necessary information about meals that are served when a dining program is offered, the organization demonstrates how nutritional information can be provided. This standard does not require a printed menu.

Examples
Nutrition information such as caloric content, dairy-free, gluten-free, or nut-free could be listed on the meal schedule or menu.

A whiteboard is posted in the dining room and personnel write nutritional information about the specific meal being served that afternoon.

When serving a meal, personnel are able to describe nutritional details when individuals with specific dietary needs or questions ask about the food being served.

3.B. 10. The program:

a. Has written indicators to measure the following:
   (1) Falls.
   (2) Wellness.

b. At least annually addresses:
   (1) Performance in relationship to established targets in each area.
   (2) Trends.
   (3) Actions for improvement.
   (4) Results of performance improvement plans.
   (5) Necessary education and training of:
       (a) Persons served.
       (b) Families/support systems.
       (c) Personnel.

Intent Statements
The organization determines which topics personnel need in accordance with their job responsibilities. Not all personnel may need to be educated on all of the topics.

3.B. 11. As appropriate to their roles, the program provides training for personnel:

a. At:
   (1) Orientation.
   (2) Regular intervals.

b. That includes information on:
   (1) Aging process.
   (2) Dementia.
   (3) Disease management.
   (4) Fall prevention.
   (5) Pain management.
   (6) Performance measurement and management.
   (7) Safeguarding health records.
   (8) Topics identified by:
       (a) Persons served.
       (b) Personnel.
   (9) Workplace violence.
   (10) Working with external entities.
3.B. 12. The program implements written procedures that address:
   a. Conducting criminal background checks of all personnel.
   b. Timeframes for criminal background check verification, including:
      (1) Prior to the delivery of services to the persons served.
      (2) Throughout employment.
   c. Actions to be taken in response to the information received.
   
   a. Medications.
   b. Mental and behavioral healthcare providers involved in care, including contact information.
   c. Mental health status.
   d. Photograph (for identification of the person served).
   e. Prosthetics and orthotics information.
   f. Risk factors.
   g. Spiritual preferences.
   h. Vision.

3.B. 13. To advance the field of assisted living, leadership supports the program’s participation in research opportunities.

Intent Statements

It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

3.B. 14. Current emergency information is readily available in writing for each person served that includes, as applicable:
   a. Advance directives or end-of-life issues.
   b. Allergies and sensitivities.
   c. Behavioral symptoms.
   d. Cognitive status.
   e. Current diagnoses/conditions and history.
   f. Emergency contact information.
   g. Equipment and devices.
   h. Functional status.
   i. Healthcare providers involved in care, including contact information.
   j. Communication needs.
   k. Hospital preference.
   l. Immunization status.
   m. Insurance information.
   n. Legally appointed decision maker(s), including contact information.
   o. Medications.
   p. Mental and behavioral healthcare providers involved in care, including contact information.
   q. Mental health status.
   r. Photograph (for identification of the person served).
   s. Prosthetics and orthotics information.
   t. Risk factors.
   u. Spiritual preferences.
   v. Vision.

3.B. 15. There are regular meetings between personnel and the persons served to discuss issues concerning the living environment.

Intent Statements

See the Glossary for the definition of regular.

Examples

Meetings may be held monthly, quarterly, or annually and may include town-hall meetings with person served tenants to provide an overview of scheduled repairs or renovations, updated safety procedures, new laundry equipment and how it works, information about using updated thermostats in apartments, parking lot changes, or other topics regarding the living environment. Communications might also be meetings with individual persons served or with groups of persons served such as individuals living on a certain floor of a building or neighborhood of a campus.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Marketing packet with information about characteristics of populations who can be served in assisted living
- Policies and procedures regarding administration of PRN (as needed) medications
- Measurements of falls
- Measurements of wellness topics
- Procedures regarding conducting criminal background checks of personnel
- Emergency files for persons served
- Schedules of meetings between personnel and persons served

C. Person-Centered Long-Term Care Community

Description

Person-centered long-term care communities, such as nursing homes or long-term care homes, may include freestanding homes, homes that are part of continuums of care, or homes that are part of health systems. Person-centered long-term care communities are residential programs that provide nursing and other services 24 hours a day, 7 days a week. Programs may offer long-term services, short-term services, or both to address a variety of needs.

Person-centered long-term care communities foster a holistic culture that focuses on:

- Autonomy, dignity, and individual choice of the persons served.
- Relationships among persons served, families/support systems, and personnel.
- Understanding what services persons served want, how the services should be delivered, and how the persons served can be engaged in the community.
- Persons served making decisions about the rhythm of their day, the services provided to them, and the issues that are important to them.
- Cultural competence, flexibility, and safety and security of the community.

Persons served are the experts regarding life in their home. Their voices are heard and their life stories, wishes and needs drive service delivery. Persons served and personnel celebrate the cycles of life and connect to the local community to continue relationships that nurture the quality of everyday life.

Leadership commits to continuous learning and growth, team work, empowerment, responsiveness, and spontaneity. A person-centered long-term care community is a place where persons served want to live, people want to work, and both choose to stay.
Applicable Standards

An organization seeking accreditation for a Person-Centered Long-Term Care Community program must meet the following standards:

- All standards in Section 1.
- All standards in Section 2.A.
- All standards in Section 2.B.
- Standards in Section 2.C., as applicable.
- All standards in Section 2.D.
- All standards in this Section 3.C.

3.C. 1. A person-centered philosophy:
   a. Is documented.
   b. Addresses, at a minimum:
      (1) Autonomy in decision making.
      (2) Choice.
      (3) Cultural competence.
      (4) Flexibility.
      (5) Holistic service delivery.
      (6) Individuality.
   c. Is modeled by:
      (1) Leadership.
      (2) Personnel.
      (3) Persons served.
   d. Guides service delivery.
   e. Is communicated in an understandable manner to stakeholders:
      (1) Either prior to or at the time of entry to the program.
      (2) On an ongoing basis.
   f. Is reflected on an ongoing basis in the engagement of stakeholders.

Intent Statements

A PCLTCC has a written statement expressing its dedication to the person-centered philosophy. Leadership establishes a climate where personnel and persons-served are free to engage in practices supported by person-centered philosophy. Persons served may experience quality of life with an emphasis on meaningful engagement. This philosophy is emphasized at all levels of the program.

Examples

1.a. The dedication to person-centered philosophy can be expressed in the program’s written mission, vision, or values statement. The written statement could also be in a variety of other materials, such as a prospective participant information brochure or packet, admissions packet, contract, admissions agreement, residence and care agreement, life lease, or participant agreement.

1.b.(1) Autonomy in decision making may include deciding to participate in a wellness program, choosing clothing for the day, or determining who is their family and support system.

1.b.(5) Holistic service delivery involves maintaining the highest quality of life for persons served, including their physical, emotional, social, spiritual, and mental health. This can be achieved through a comprehensive program of services.

1.c. Leadership may model the person-centered philosophy by encouraging relationships between persons served and personnel. Personnel partner with persons served to make decisions on service delivery. Persons served feel comfortable taking requests to personnel and feel confident that their requests will be honored.

3.C. 2. Appropriate placement of each person served is addressed through:
   a. The entry criteria.
   b. The transition criteria.
   c. The exit criteria.
   d. The resources available.
   e. Any resources previously used.
   f. Initial and ongoing screenings/assessments.
   g. The person’s potential to benefit.
   h. The person’s personal preferences.

Intent Statements

This standard focuses on how information about the long-term care program is used to help ensure that the persons served are in the right setting to address their needs. The organization should be able to discuss how information regarding when it is appropriate for a person served to move into a long-term care setting,
when it may be necessary for that individual to transition to a higher level of care within the organization or outside of the organization, and under what circumstances it would be necessary for a person served to leave the long-term care organization are used to make such decisions. Even though referral sources and funders may be involved in placement of persons served, organizations should demonstrate their role in this process because they are ultimately accountable for providing appropriate care.

Examples
2.e. Previously used resources might include whether the person served received physical therapy and would continue to need this service when in long-term care.

Examples
3.h. Social might include social work or social services.
3.j. For each type of service listed, the program may indicate whether the person served may obtain services at the long-term care program or have to be transported to another location to receive the service. Capacity may refer to the space, equipment, or personnel who provide the service. Timeliness of response to orders and timeliness of results to the clinician might give information about how long the steps take to activate the service once it is ordered, prescribed, or determined necessary.

Intent Statements
In making decisions about where and how to seek services, persons served should be aware of how various services may be accessed. Referral sources can also benefit from clarity so that they are able to ensure appropriate placement for persons served. Services may be provided directly by the program, arrangements may be made to obtain the services from a contracted agency, or a referral to another provider might be made.

Examples
Documenting of information about services can occur in a handbook, on a web site, in fact sheets, or other legible material. Sharing of information regarding important types of services may be conducted by personnel to other parties such as referral sources and persons served via meetings, tours, phone calls, or one-on-one discussions.

3.g. Rehabilitation could specify physical, occupational, speech-language, or other types.
3.h. Social might include social work or social services.
3.j. For each type of service listed, the program may indicate whether the person served may obtain services at the long-term care program or have to be transported to another location to receive the service. Capacity may refer to the space, equipment, or personnel who provide the service. Timeliness of response to orders and timeliness of results to the clinician might give information about how long the steps take to activate the service once it is ordered, prescribed, or determined necessary.
3.C. 5. There is identification and celebration of life-cycle events that are important and meaningful to:
   a. Persons served.
   b. Families/support systems.
   c. Personnel.

Intent Statements
The PCLTCC takes opportunities to celebrate together events that have meaning in the lives of the person served and their family/support system.

Examples
As part of the information shared when a person moves into the organization or program, persons served are asked about important events throughout the year that they typically celebrate.
Families are encouraged to inform personnel about upcoming events that are special to the person served.
Families and friends are invited and participate in birthdays/anniversaries for each person served.
Milestone events in the lives of persons served are planned for and celebrated with personnel and the persons served.
Families feel welcomed to celebrate family events in the community with their loved ones and friends. For example, a family brings Christmas presents and opens them with their grandmother.

3.C. 6. On an ongoing basis, the program:
   a. Assesses the capacity of persons served to make decisions.
   b. Educates persons served regarding the consequences associated with choices and behaviors that pose a potential risk to their health or safety.
   c. Facilitates discussion for decision making.
   d. Minimizes barriers to decision making by the persons served.
   e. Documents discussions and decisions made by the persons served in their records.

Examples
6.a. Assessment of decision-making capacity may be done in consultation with the family/support system and/or in consultation with or by the physician in order to ensure that the assessment is done correctly.

3.C. 7. The long-term care program addresses risk reduction for each person served through:
   a. Written assessment of potential risks in the following areas:
      (1) Behavior.
      (2) Cognition.
      (3) Communication.
      (4) Dental.
      (5) Function.
      (6) Health.
      (7) Physical.
      (8) Medication.
      (9) Nutrition.
      (10) Pain management.
      (11) Psychosocial.
      (12) Recreation and leisure.
   b. Actions to mitigate identified risks.

3.C. 8. The program demonstrates an ongoing process to:
   a. Educate the persons served that they have choice.
   b. Document the preferences of the persons served.
   c. Communicate with all relevant stakeholders the preferences of the persons served.
   d. Implement person-centered plans in accordance with the preferences of the persons served.

Intent Statements
To achieve a person-centered culture, leadership and personnel are able to show how, on an ongoing basis through various approaches, the possibility of making choices and communicating
preferences is strongly embedded in how services are provided.

3.C. 9. The program fosters a relationship-centered culture in which the persons served and all personnel are empowered to make decisions in partnership based on the preferences, strengths, and needs of the person served.

Intent Statements
A relationship-centered culture is inherent to person-centered care. It is focused on establishing positive, meaningful interactions between persons served and personnel to enhance quality of life and quality of care. Persons served are empowered, in accordance with their skills and abilities, to make decisions. Relationships help to ensure that individuals have a better understanding of one another.

3.C. 10. Based on the individual needs of the persons served, the long-term care program provides or arranges for:
   a. Health promotion.
   b. Services that prevent illness.
   c. Health screenings.
   d. Disease management.

Examples
10.a. Health promotion is the process of helping people to take control over their lives so that they can choose options that are health giving rather than those that are health risky, such as reducing sugar intake, exercising, drinking plenty of water, washing hands regularly, or other behaviors.
10.b. Services might include annual shots to prevent flu and/or pneumonia.
10.c. Health screenings could be events or activities set up to support health promotion. They could include mammography screenings, dental screenings, blood pressure testing or other types of screenings.
10.d. Disease management could refer to a system of coordinated interventions where self-care efforts are significant in managing chronic conditions. Examples of disease management include an individual with diabetes receiving regular blood sugar monitoring or an individual with asthma receiving regular breathing treatments to avoid acute asthma episodes.

3.C. 11. In accordance with the preferences and choices of the persons served and their families/support systems, the program provides opportunities that encourage:
   a. Social contacts:
      (1) Within the program.
      (2) External to the program.
   b. Relationships:
      (1) Within the program.
      (2) External to the program.

3.C. 12. The program demonstrates the ability to incorporate sensory stimulation into the person-centered plan for those with dementia.

Intent Statements
Sensory stimulation for persons served with dementia has been shown to decrease agitation and restlessness as well as improve sleep. These symptoms are very common in most forms of dementia, and certainly in people with Alzheimer’s, so sensory stimulation results in improved quality of life for the persons served as well as for caregivers. Examples of purposeful use of sensory stimulation for individuals should be described to surveyors.

Examples
Sensory stimulation can be anything that stimulates one of the five senses. Music, visual arts, movies, a joke or story, an interesting tactile object, or a pleasant smell may provide appropriate sensory stimulation.

3.C. 13. In response to the preferences of the person served, the program:
   a. Assesses the person’s use of complementary health approaches.
   b. Educates the person served on the efficacy and safety of interventions.
   c. Provides information and resources on integrative health, as appropriate.
Examples
According to the National Institutes of Health National Center for Complementary and Integrative Health (nccih.nih.gov/health/integrative-health), the terms complementary and alternative refer to the use of healthcare approaches developed outside of mainstream Western, or conventional, medicine. Complementary medicine is the use of a non-mainstream approach together with conventional medicine. Alternative medicine is the use of a non-mainstream approach in place of conventional medicine. Most use of non-mainstream approaches by Americans is complementary. Integrative health incorporates complementary health approaches into mainstream healthcare.

Complementary health approaches may include:
■ Use of natural products, such as dietary supplements.
■ Mind and body practices, such as acupuncture, massage therapy, meditation, movement therapies, yoga, and relaxation techniques.
■ Homeopathy, naturopathy, and traditional healers.

Resources
■ National Center for Complementary and Integrative Health (NCCIH): nccih.nih.gov
■ National Cancer Institute Pain Control: Support for People with Cancer: www.cancer.gov/publications/patient-education/pain-control
■ National Institutes of Health Office of Dietary Supplements: ods.od.nih.gov
■ MedlinePlus Herbs and Supplements: www.nlm.nih.gov/medlineplus/druginfo/herb_All.html
■ American Cancer Society Complementary and Alternative Medicine: www.cancer.org/treatment/treatmentsandsideeffects/complementaryandalternativemedicine/index
■ US Food and Drug Administration Dietary Supplements: www.fda.gov/food/dietarysupplements
■ Mayo Clinic: www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/alternative-medicine/art-20045267

3.C. 14. The rhythm of daily life is directed by each person served, as demonstrated by:

a. Freedom to make choices regarding the cycle of each day, including:
   (1) Bathing.
   (2) Dressing.
   (3) Eating.
   (4) Hygiene.
   (5) Oral care.
   (6) Sleeping.
   (7) Waking.

b. Choice of clothing.

c. Choice of grooming style.

d. Each person’s choice to participate in personally meaningful customary routines, including, but not limited to:
   (1) Cleaning.
   (2) Community activities.
   (3) Contact with pets.
   (4) Cooking.
   (5) Exercise/mobility activities.
   (6) Gardening.
   (7) Hobbies.
   (8) Intimacy.
   (9) Recreation.
   (10) Social interaction.
   (11) Spiritual/religious activities.

Intent Statements
Individuals in a PCLTCC direct the rhythm of their daily life. From rising in the morning to retiring in the evening, the choice of the daily routine is determined by the person served. It is not dictated by the convenience of the personnel or by a schedule designed to create efficiency. Being able to accommodate the person’s rhythm
of daily living is a hallmark of person-centered long-term care. Persons served should not have to give up everything they are accustomed to when entering long-term care. Participating in the life of the community while maintaining their daily routine is crucial for their quality of life. Living in a community always includes the freedom to exercise individual rights and respect for the rights of others.

**Examples**

Persons served can be afforded opportunities to continue activities they enjoy in their community as well as to pursue activities that will support their growth and development. Some examples of these include:

- Choosing when to wake up, nap, and retire.
- Choosing the schedule for completing their ADLs.
- Participating in meal preparation.
- Creating a garden of flowers or vegetables for use in the community.
- Caring for or simply enjoying the companionship of pets.
- Continuing to participate in activities such as the Rotary, League of Women Voters, or church groups.
- Tutoring students in English as a second language.
- Assisting personnel with tax preparation.
- Engaging in intimacy with a spouse or significant other.
- Enjoying familiar recreational activities.
- Learning a new hobby or skill.
- Opportunities to engage in meaningful work, if desired.
- Engaging in meaningful interactions with other residents, personnel, and members of the local community.

Persons served who wish to do so can be encouraged to participate in the daily routine of their community by continuing to do the things they did at home (e.g., setting the table, dusting, doing laundry, gardening, woodworking.)

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**3.C. 15.** Policies and written procedures address nursing services, including assessment, implementation, and planning, as well as critical decision making regarding:

- Education related to identified needs of persons served.
- Post medical/surgical care issues.
- Medications.
- Pain.
- Rehabilitation issues.
- Skin integrity.
- Need for specialty consultation.

**Examples**

15.b. Services could include incision care, Foley catheter care, deep vein thrombosis prevention, and respiratory care.

**3.C. 16.** Policies and written procedures address:

- Who provides medical management for the persons served.
- Who provides rehabilitation management for the persons served, if applicable.
- When these are not the same physician, mechanisms for coordination, communication, and collaboration.
- Primary responsibility for medical management, including:
  1. Description of the role and responsibilities of the attending physician.
  2. Description of the roles and responsibilities of other physicians who provide concurrent medical services.
  3. Physician availability.
  4. Appropriate medical decision making.
- Availability of the physician or his or her designee 24 hours a day, 7 days a week.
f. Access to consulting physicians to treat continuing, unstable, or complex medical conditions.

g. Prevention, including:
   (1) Prevention of further disability.
   (2) Medical complications.
   (3) Adverse events.

Intent Statements
The rehabilitation physician is a physical medicine and rehabilitation physician (physiatrist) or a physician (neurologist, orthopedist, etc.) who is qualified by virtue of specialized training and experience in rehabilitation to provide rehabilitation management for the persons served. The rehabilitation physician clearly identifies medical necessity as well as continuing rehabilitation stay.

16.e. A designee is another physician who is chosen by the rehabilitation physician to assist with providing coverage to meet the needs of the persons served.

Examples
Specialized training and experience for the rehabilitation physician may be demonstrated by a formal residency in physical medicine and rehabilitation, a fellowship in rehabilitation for a minimum of one year, or a minimum of two years’ experience as a collaborative team member providing rehabilitation services.

16.d.(3) The program addresses physician availability in the event the physician is ill, on vacation, called to jury duty, or attending CME.

3.C. 17. The program communicates in a timely manner with the physician(s) of each person served at the time of:
   a. Entry.
   b. Significant changes in the status of the person served.
   c. Exit/transition.

3.C. 18. When crisis management is necessary to manage behaviors of the persons served, personnel demonstrate appropriate use of emergency crisis procedures.

Intent Statements
An unstable or dangerous situation affecting an individual, a group, or the organization can prompt implementation of procedures that are appropriate to the situation and in line with the person-centered plan for the person served.

3.C. 19. The long-term care organization’s privileging process defines:
   a. Which professionals require privileges to provide services in the long-term care program.
   b. Qualifications.
   c. Experience and training required to provide professional services in the long-term care program.
   d. Specific privileges granted.
   e. Specific responsibilities in accordance with the privileges granted.
   f. A system to monitor performance in executing the privileges granted.
   g. A system to address modification or withdrawal of privileges.
   h. A mechanism to demonstrate current competency relative to the privileges granted.
   i. A system to ensure that practice is consistent with the privileges granted.

Intent Statements
The organization determines which professionals are subject to the privileging process in order to provide services to persons served in the long-term care program. The privileging process may be implemented and monitored through the organization’s credentialing system and medical or professional staff oversight. Credentialing and privileging process will clearly identify who the qualified physicians are and their role in preadmission, admission, continued stay, and exit/transition activities. This process should also assist with the identification of the roles of physician extenders, consulting physicians, residents/fellows and students.
3.C. 20. The medical director for the program:
   a. Is licensed by a professional governing body.
   b. Demonstrates appropriate experience and training to provide physician services through a minimum of two years’ experience as a collaborative team member providing physician services in a long-term care program.
   c. Maintains his or her:
      (1) Licensure.
      (2) Certification.
      (3) Privileges in the organization.
   d. Participates in active clinical practice that relates to the population served.
   e. Demonstrates currency in medical practice concerning the persons served, including dementia management.
   f. Demonstrates active learning and involvement in the professional community.

Example Statements
If a physician provides direction to the program, he or she has and continues to demonstrate experience and/or training as well as ongoing engagement in the long-term care field. It is expected that the physician is board certified in his/her specialty.

Examples
The medical director of the long-term care program is board certified in geriatric medicine and is a certified medical director. The medical director regularly makes presentations at meetings and writes for journals on issues related to long-term care.
A medical director is board certified in internal medicine and has worked with residents with dementia for the past ten years. This individual is active in and volunteers with the local Alzheimer’s Association. Annually, he/she attends medical education programs that present information on current dementia care issues.

3.C. 21. The medical director for the program:
   a. Has a written agreement with the organization that outlines his or her responsibilities.
   b. Actively participates in:
      (1) Ensuring the adequacy of individual treatment prescriptions and programs, including notations of contraindications and precautions, developed with the participation of professional personnel.
      (2) The development of ongoing relationships with the medical community.
      (3) Educational activities with the program personnel.
      (4) The establishment of policies and written procedures that identify the functions and responsibilities of the physician.
      (5) Performance improvement activities.
      (6) Advocacy activities.
      (7) Program development and modification.
      (8) Establishing the program’s policies and procedures.
      (9) Resource utilization management.
      (10) Stakeholder relationship management.
      (11) Marketing and promoting the program.
      (12) Strategic planning.
      (13) Financial planning and decision making.
      (14) Ethical decision making.

Examples
21.b.(4) The policies for physicians clearly address their role and responsibilities in processes from preadmission through admission, continuing stay determination, and discharge.
21.b.(10) Stakeholder relationship management includes the development of and participation with stakeholders of the program, such as the
medical directors of insurance companies the program works with and other physicians who refer to the long-term care program or would benefit from education about the program.

3.C. 22. The program fosters teamwork among personnel that addresses:
   a. Individual strengths.
   b. Mentoring.
   c. Opportunities for performance improvement.
   d. Education and skills development regarding team dynamics.

3.C. 23. As appropriate to their roles, the organization provides documented competency-based training for personnel:
   a. At:
      (1) Orientation.
      (2) Regular intervals.
   b. That includes information on:
      (1) Aging process.
      (2) Assisting persons served with activities of daily living.
      (3) Behavior management.
      (4) Dementia.
      (5) Disease management.
      (6) Efficient utilization of healthcare resources.
      (7) Fall prevention.
      (8) Pain management.
      (9) Performance measurement and management.
      (10) Prevention related to:
           (a) Recurrence of the illness, injury, impairment, or disability.
           (b) Potential risks and complications due to the illness, injury, impairment, or disability.
      (11) Psychosocial issues.
      (12) Safeguarding health records.
      (13) Topics identified by persons served.
      (14) Topics identified by personnel.
      (15) Wellness.
      (16) Working with external entities.

3.C. 24. Leadership fosters a continuous learning environment for personnel that:
   a. Identifies and develops emerging leaders.
   b. Measures the satisfaction of personnel with the learning opportunities.
   c. Addresses performance improvement of the learning environment as needed.

Intent Statements

Education of personnel who care for the persons served has been identified as a key component. Leadership ensures that the program has processes in place for initial and ongoing education designed to meet the needs of each staff member.

The program identifies the best way for each of its personnel to learn. For some it is in a classroom; for others it is a hands-on approach with a return demonstration; for others it is self-directed, computer-based education; and for others, it is a group discussion. Leadership ensures that personnel receive the education they need in the style best suited to their needs.

Examples

There may be opportunities for personnel to evaluate the program’s teaching mechanisms, how they have been coached, and the feedback they have received from their supervisors. Leadership models the desired behaviors for personnel.

Direct care personnel might need to make on-the-spot decisions that have traditionally been first cleared with their supervisor. Supervisors might need ongoing coaching to help them empower and support the direct care personnel to be decision makers.

Persons served, families/support systems, and personnel may be involved in the creation of a curriculum as well as in the initial and ongoing
An organization has a caregiver award, with nominations and selection done by the residents. Persons served and family members are encouraged to provide feedback regarding personnel at care plan meetings.

3.C. 27. To advance the field of long-term care, leadership supports the program’s participation in research opportunities.

Intent Statements
It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

3.C. 28. The program provides or arranges for family/support system education on how to access resources on behalf of the person served.

Examples
Resources could include nutritional information, websites that offer information on ordering adaptive equipment, catalogues with activity items that interest the persons served, guidance on how to order certain publications, or other resources to enhance their quality of life or quality of care.

3.C. 29. In accordance with the choice of the person served, the program provides or arranges for education on financial assistance and planning for persons served and families/support systems that addresses:

a. Benefits.
b. Sustainability of services.
c. Contingency planning.
d. Short- and long-term planning for future services, including:
   (1) Funding and supports available.
   (2) Eligibility criteria.
   (3) Range of services available.
   (4) Amount of services available.
   (5) Impact on continuing benefits.
Intent Statements

Long-term services and supports might have multiple payer sources and therefore various forms, systems, offices, and criteria that persons served and their families/support systems must navigate. This standard is not prompting organizations to serve as financial planners; instead, it recognizes that long-term care providers are often aware of ways that persons served can get information from the local community or other resources regarding various payers for services and plan for what may or may not be covered.

Examples

A speaker from a government agency comes to do a presentation for personnel and persons served regarding benefits for certain services. Brochures regarding prescription drug benefits for moderate income persons describes where to call for more information regarding accessing benefits.

A social worker is available to provide persons served with information regarding limitations in government payment of rehabilitative services and how to appeal coverage decisions.

3.C. 30. The long term care program:

a. Gathers information on a representative sample of the persons served, including information on:
   (1) Behavior.
   (2) Function.
   (3) Health.
   (4) Medication.
   (5) Nutrition.
   (6) Pain management.
   (7) Psychosocial.
   (8) Recreation and leisure.

b. At least annually addresses:
   (1) Performance in relationship to established targets in each area.
   (2) Trends.
   (3) Actions for improvement.

(4) Results of performance improvement plans.

(5) Necessary education and training of:
   (a) Persons served.
   (b) Families/support systems.
   (c) Healthcare providers.

Intent Statements

The information gathered is at the level of the program (a representative sample of persons served within the long-term care program). Targets are established for the long-term care program based on analysis of the representative sample of persons served.

Examples

30.a.(1) Behavior could include verbalizations; pacing; lack of recognition of place or person; repetition or words, phrases, or questions; suspicion of others; wandering; and changes in sleep.

30.a.(2) Function could be related to activities of daily living such as eating, bathing, dressing, toileting, transferring (walking), and continence.

30.a.(3) Health could include unplanned medical visits due to illness, medication side effects, and falls.

30.a.(4) Medication could include reduction in use of anti-psychotics, reducing number of medications taken by individuals, or adverse side effects from medications.

30.a.(5) Nutrition could include vitamin levels, weight maintenance, and adherence to special diets.

30.a.(6) Pain management could include pain assessment, effectiveness of pain medicine, and use of other pain treatments.

30.a.(7) Psychosocial might include effectiveness of psychosocial interventions for behavioral health conditions or completion of a psychosocial assessment in a specified period of time.

30.a.(8) Recreation and leisure might include participation in group activities.
3.C. 31. The program demonstrates the ability to incorporate into the person-centered plan:
   a. A palliative approach to care.
   b. End-of-life care.

Examples

Individuals with severe and irreversible conditions might no longer be able to eat at the end of life and might need only comfort care. For example, they may have their mouths moistened and be given oral care.

When persons served are near the end of life, artificial nutrition and hydration might be withheld in accordance with their wishes or advance directives.

Persons served and their families/support systems may receive information about palliative care options, including hospice, when residents appear to have entered the final stages of life. Such signs could include the person's inability to walk without assistance, inability to sit up without support, inability to smile, unrecognizable speech, and swallowing problems.

The program should demonstrate an understanding of personal choice and implement programs to support these choices at the end of life. Programs should support the choices of persons served and should also encourage them to make these known to personnel.

3.C. 32. Current emergency information is readily available in writing for each person served that includes, as applicable:

   a. Advance directives or end-of-life issues.
   b. Allergies and sensitivities.
   c. Behavioral symptoms.
   d. Cognitive status.
   e. Communication status.
   f. Current diagnoses/conditions and history.
   g. Emergency contact information.
   h. Equipment and devices.
   i. Functional status.
   j. Healthcare providers involved in care, including contact information.
   k. Hospital preference.
   l. Immunization status.
   m. Insurance information.
   n. Legally appointed decision maker(s), including contact information.
   o. Medications.
   p. Mental and behavioral healthcare providers involved in care, including contact information.
   q. Mental health status.
   r. Photograph (for identification of the person served).
   s. Prosthetics and orthotics information.
   t. Risk factors.
   u. Spiritual preferences.
   v. Vision.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Documentation in a resident handbook of the organization’s philosophy regarding person-centered care
- Documentation in an employee handbook of the organization’s philosophy regarding person-centered care
- Admission criteria
- Criteria that may prompt a transition for additional care
- Discharge criteria
- Resident Bill of Rights
- Assessment tools
- Documented preferences in the person-centered plan for each person-served
Section 3.D. Home and Community Services

D. Home and Community Services

Description

Home and Community Services (HCS) are person centered and foster a culture that supports autonomy, diversity, and individual choice. Individualized services are referred, funded, and/or directed by a variety of sources. In accordance with the choice of the person served, the services provided promote and optimize the activities, function, performance, productivity, participation, and/or quality of life of the person served.

The Home and Community Services may serve persons of any ages, from birth through end of life. Services may be accessed in a variety of settings including, but not limited to, private homes, residential settings, schools, workplaces, community settings, and health settings. Services are provided by a variety of personnel, which may include health professionals, direct support staff, educators, drivers, coaches, and volunteers and are delivered using a variety of approaches, supports, and technology.

Services are dynamic and focus, after a planning process, on the expectations and outcomes identified by both the person served and the service providers. The service providers are knowledgeable of care options and linkages to assist the person served; use resources, including technology, effectively and efficiently; and are aware of regulatory, legislative, and financial implications that may impact service delivery for the person served. The service providers are knowledgeable of their roles in and contribution to the broader health, community, and social services systems.

Home and Community Services must include at least one of the following service delivery areas:

- Services for persons who are in need of specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need.
- Services for persons who need assistance to access and connect with family, friends, or coworkers within their homes and communities.

Handbook for families/support systems identifying resources and information about the long term care program
- Procedures for personnel identifying how they understand and support the individual rhythm of the day for each person served
- Policies and procedures regarding medical/physician involvement in the program
- Written privileging processes
- Documentation about the roles and responsibilities of the medical director
- Training schedules and topics addressed
- Survey used to measure personnel satisfaction
- Emergency files for each person served
Services for persons who need or want help with activities in their homes or other community settings.

Services for caregivers that may include support, counseling, education, respite, or hospice.

**NOTE:** A service provider seeking accreditation for Home and Community Services is not required to provide all four of the service delivery areas identified in the service description. However, it must include in the site survey all of the service delivery areas it provides that meet the service description.

**Applicable Standards**

All organizations seeking accreditation for Home and Community Services must meet:

- All standards in Section 1.
- All standards in Section 2.A.
- Standards in Section 2.C., as applicable.
- All Standards in Section 2.D., if Standards 3.D.16.–18. in this section are applicable to the program.
- Standards 1.–15. in this Section 3.D.

### 3.D. 1. To facilitate the appropriate level of services/supports for the person served, the home and community services demonstrate knowledge of and the ability to identify appropriate service options/settings.

**Intent Statements**

Services are individualized to the persons served. The home and community services may provide a full spectrum of services or only one type of service but demonstrate an awareness and use of community resources that may be used to support or enhance services to the person served.

### 3.D. 2. The home and community services identify and address gaps in service delivery.

**Intent Statements**

The HCS may address gaps in service at both the level of the person served and the level of the program/service.

**Examples**

Gaps in service delivery for a person served may be addressed by referring the person to another program/service in the local community or contracting with an external provider to engage with the team of the person served. For example a therapist working with a person served observes that the person is no longer able to do household chores because of pain and lack of mobility and as a result, there are now concerns about the safety and cleanliness of the home. The therapist could refer the person back to the primary physician for medical evaluation of medical and a potential referral for homemaker services.

At the level of the program/service, the HCS may explore developing a new service, partnering with another provider in the community to provide or develop additional services, or advocating with a payer to cover services that are not currently covered.

### 3.D. 3. To verify the backgrounds of all personnel, written procedures identify actions to occur:

- a. Prior to the delivery of services to the persons served or to the organization.
- b. At stated intervals throughout employment.
- c. In response to the information received.

**Intent Statements**

This standard relates to Standard 1.I.4. To reduce risk and ensure the safety of the persons served, the organization defines its process to verify backgrounds of all personnel and take action when appropriate. The organization has procedures in place in the event that backgrounds or credentials cannot be verified. Continued employment might be contingent upon positive verification for some positions; the organization determines when this is the case.

**Examples**

The nursing assistant, home health aide or driver may attend orientation but not provide direct service to the persons served until background verification is complete.
Section 3.D. Home and Community Services

3.D. 4. Personnel demonstrate competencies in the delivery of home and community services, including, but not limited to:

   a. Addressing the unique needs of persons served.
   b. Communication with persons served and their families/support systems.
   c. Communication with other providers serving the persons served.
   d. Facilitating active involvement of the persons served and families/support systems in the service delivery process.
   e. Facilitating behavioral supports.
   f. Facilitating cognitive interventions.
   g. Handling developmental/life transitions.
   h. Knowledge of community resources.
   i. Recognition and reporting of suspected abuse and neglect.
   j. Setting and maintaining professional boundaries.

Intent Statements

In Section 1.I. Workforce Development and Management standards, organizations are asked to identify skill sets that would assist with the achievement of the outcomes for the persons served as well as organizational mission and goals. This standard identifies areas that would be included in orientation as well as ongoing training as appropriate for the HCS. These are not the only skill sets that an HCS program may include but these should be evident.

Examples

These competencies can be obtained through formal education or continuing education focused on persons served; on-the-job training; mentorship by experienced personnel; ongoing access to books, periodicals, and videos; etc.

4.f. A person served may need to establish techniques to assist with memory of daily tasks that should be completed for health or safety purposes. These aids may be written, electronic, phone calls, etc. Personnel are able to appropriately use or encourage the person served to use the pertinent memory aid.

4.g. Transitions could be from home to job, school to supported or independent living, job to retirement, job to volunteering, or independent living to supported living.

4.h. Having knowledge of services available in the outside community to assist others in adding services as needed. Client is homebound and needs someone to recommend a transportation service that has companion service to attend client.

3.D. 5. Policies and written procedures are implemented that address, at a minimum, the following service delivery issues:

   a. Availability of appropriate equipment, supplies, etc., at the service delivery site from initial service delivery through exit/transition.
   b. Confidentiality and privacy of information concerning the persons served in the home and community environments.
   c. Clarification of the roles and responsibilities of:
      (1) Families/support systems.
      (2) Service providers.
      (3) Others, as appropriate.
   d. Contingency plans if either the family/support system or the service provider is unable to deliver care.
   e. Unsuccessful delivery of services.
   f. Referral/transition to other services.
   g. Assignment of personnel in accordance with the needs and choices of the persons served.
   h. Within the scope of services, the availability of home and community services to respond to:
      (1) Persons served.
      (2) Families/support systems.
      (3) Service providers.
      (4) Other stakeholders.

Intent Statements

Home and community services are offered to persons served in a variety of settings. Policies
and procedures address the uniqueness of the settings and types of situations staff members may encounter when decisions need to be made, potentially on an immediate basis, without the “on-site” support of supervisors or others who are typically available in a facility-based program.

Examples
5.e. Unsuccessful delivery of services may be the result of an issue on the part of the provider or the person served. Person refused service, care worker could not complete assignment, scheduling error, equipment not available or weather emergency.

5.h.(1) The scope of the services may be focused only on therapeutic interventions and not include social reintegration activities.

5.h.(2) The scope of the services may include the availability of respite services for family/support systems.

3.D. 6. A risk assessment of each person served addresses the following areas:
   a. Behavioral.
   b. Cognitive.
   c. Communication.
   d. Developmental.
   e. Emotional.
   f. Environmental.
   g. Physical.
   h. Capability of the family/support system.
   i. Other, as appropriate.

Intent Statements
To decrease the potential of harm to the person served, risk assessments are an integral part of home and community services. The analysis of this information may result in changes to the person-centered plans as well as improvement at the level of the services.

Examples
6.c. Risks in communication may be the inability to communicate emergent needs, inability to understand verbal or written communication, or different languages being spoken by the person and staff.

6.e. A person served may exhibit signs of severe depression, and suicide prevention approaches may be warranted.

6.g. Physical risks may include the potential for falls or impulsivity on the part of the person served when moving around his or her home.

6.h. Risk assessment related to the family/support system might include the availability of the family/support system, its understanding of the health status of and safety precautions required for the persons served, and family/support system dynamics.

3.D. 7. Service delivery is scheduled at an agreed-upon time that supports the person-centered plan.

Intent Statements
There is a system in place to determine the most appropriate schedule for service delivery based on the lifestyle and preferences of the persons served and the scope of the home and community services.

Examples
Person served rises late morning or prefers late in the day appointment.

3.D. 8. In accordance with the choice of the person served, the home and community services assist the person served to develop a disaster preparedness and emergency plan that considers the following:
   a. Assessment of the current knowledge of:
      (1) The person served.
      (2) The family/support system.
   b. Assessment of the physical environment where services are delivered, including accessibility of the environment.
   c. Identification of modifications necessary to ensure safety in the event of an emergency.
d. Community resources, including:
   (1) Identification of resources for:
      (a) Evacuation.
      (b) Shelter.
      (c) Recovery.
   (2) Accessibility of resources for:
      (a) Evacuation.
      (b) Shelter.
      (c) Recovery.

e. Basic needs in the event of an emergency.

f. Identification of circumstances in which service delivery can be postponed or omitted.

g. Provisions for communication by personnel while providing services regarding decisions to continue or discontinue services.

h. Contingency plans for:
   (1) The person served.
   (2) The family/support system.
   (3) Personnel.

Intent Statements
Persons served by HCS are at risk in emergent situations because of a variety of issues including age, developmental, cognitive, and physical levels of functioning. To address these risks persons served can seek, if they desire, to receive more information from the HCS on how to address emergent situations.

8.d.(1)(c) and 8.d.(2)(c) Recovery after a disaster means the return of the person served to his or her home or community setting.

Examples
8.e. Basic needs may include food, water, utilities, medications, oxygen etc.

Resources
- U.S. Department of Transportation: www.dotcr.ost.dot.gov/asp/emergencyprep.asp
- Disaster Resources for People with Disabilities and Emergency Managers: www.jik.com/disaster.html
- Special supplement to ACA InMotion When Disaster Strikes-a Pocket Survival Guide: www.amputee-coalition.org/inmotion/jan_feb_08/pocket_survival_guide.html
- National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities: www.diversitypreparedness.org
- The Disaster Recovery Information Exchange (DRIE) has chapters throughout Canada: www.drie.org
- Public Safety and Emergency Preparedness Canada: www.publicsafety.gc.ca Provincial or territorial emergency measures organizations can also be used as resources.
- Disaster Preparedness for People with Disabilities: www.disability911.com
- The Canadian Centre for Emergency Preparedness: www.ccep.ca
3.D. 9. If the person served uses assistive technology, electronic aids to daily living, environmental controls, equipment, environmental modifications, and/or personal emergency response systems, the home and community services, on an ongoing basis:
   a. Determine that the technology and/or equipment:
      (1) Functions properly.
      (2) Achieves the intended purpose.
   b. Notify the appropriate designee, as needed.
   c. In accordance with the person-centered plan, incorporate the technology and/or equipment into service delivery.

Intent Statements
Technology has an ever-increasing presence in home and community services. It is important that service providers are attuned to the role and impact of technology on the lives of the persons served. The extent to which the service provider interacts in the environment in which technology is used by the person served guides the involvement of the service provider in the activities of this standard.

3.D. 10. In accordance with the choice of the person served, the home and community services partner with the family/support system throughout the service delivery process, including ongoing consideration of:
   a. The family/support system’s:
      (1) Ability and willingness to support and participate in the plan.
      (2) Composition.
      (3) Interpersonal dynamics.
      (4) Different methods of:
         (a) Engagement.
         (b) Communication.
         (c) Coping.
         (d) Problem solving.
      (5) Strengths and limitations.
      (6) Knowledge base.
   b. Unique financial, social, or cultural factors that might influence the home and community services.
   c. Health status of the primary caregiver.

Intent Statements
When the person served agrees to having members of the family/support system involved in the delivery of services, the home and community services assess the family/support system to include it effectively and optimally in the service delivery process. This assessment process can provide information that impacts the opportunity for the person to remain in his or her home or community setting.

Examples
Factors that might impact participation in service delivery or support include that members of the family/support system live at a distance, work during typical service delivery times, have limited resources to assist, etc.

10.a.(3) Interpersonal dynamics refers to the interactions between the person served and his or her spouse/significant other, friends, peers, coworkers, employer, and community.

10.a.(4) Engagement may include the ability of the family/support system to participate in training sessions, learn new skills, call or email questions or concerns to personnel when they live at a distance, and willingness to participate in the person-centered plan as appropriate.

10.a.(9) Responsibilities may include work and family-related responsibilities such as being the caregiver for young children or elderly parents.

10.b. Financial, social, or cultural factors may influence service delivery in areas such as setting goals for the person served, the provision of information and services, and exit/transition options.
3.D. 11. In accordance with the choice of the person served, policies and written procedures facilitate collaboration with the family/support system in decision making through the following:
   a. Accessible information.
   b. Timelines for exchange of information.
   c. Understanding of the information provided.

Intent Statements

To facilitate the decision-making roles of the person served and family/support system, they are given information in a way that is understandable and in sufficient time to make informed decisions.

3.D. 12. The home and community services provide education:
   a. To:
      (1) Persons served.
      (2) Families/support systems.
      (3) Other relevant stakeholders.
   b. In accordance with identified needs, that addresses, but is not limited to:
      (1) Accessing emergency care if necessary.
      (2) Communication with other service providers.
      (3) Developing a system to record personal health information.
      (4) Disease management.
      (5) Information about community resources and how to access them.
      (6) Preventive care.
      (7) Procedures unique to the provision of home and community services.
      (8) Safety issues related to the service delivery site.
      (9) Specific healthcare procedures and techniques, as appropriate.

Intent Statements

12.b.(3) Having a system or tool to record personal health information helps the persons served and their families/support systems ensure that they receive ongoing quality healthcare. Such information empowers persons served to be responsible for an important step in their care, lessens the fragmentation of care among healthcare settings, and will likely decrease the risk of medical errors.

Examples

12.a. Some organizations may have employees who provide services to persons served, but these employees are not equipped to provide education or certain services to persons served and families/support systems because it is beyond the scope of their education and their role. In this case, the employees should demonstrate how they refer the education and other needs back to another applicable entity, such as the community care access center, for response.

12.b.(2) Examples of other providers with whom the persons served, families/support systems, or other stakeholders may have to communicate might include the person’s primary care physician, pharmacist, or other rehabilitation providers in the community such as a transportation provider.

12.b.(3) The system used provides a record of relevant personal health information and is portable for persons served so that they have the appropriate information at each health encounter and healthcare providers can be efficiently informed by more complete and accurate information than might otherwise be available. The system or tool may be called many things; e.g., a portable profile, medical passport, patient care notebook, shared care plan, smartcard, and healthcare folder. Offering the person served a choice of formats may improve the actual use of the system or tool. The format facilitates ease of access and ready availability in case of an emergency. Formats might include:

- Index cards with clear writing.
- An eight-by-eleven inch piece of paper.
- Folders.
- Notebooks.
- Flash drive.
- CD.
3.D. Home and Community Services

- Bracelet with information.

12.b.(8) Examples of safety issues may include how to evacuate the service delivery site, environment modifications, and whether the service delivery site poses any safety risks to the providers of services.

Resources

12.b.(3) Although CARF does not endorse or expect the use of specific products, the following list provides links to a variety of systems and tools currently available to record personal health information.

- medfusion.net/ihealthrecord
- medicalert.org
- medicalhomeinfo.org/for_families/care_notebook
- medictag.com
- nextstepincare.org/Caregiver_Home/Personal_Health_Record/
- www.roadid.com/Common/default.aspx
- www.siebenspcc.com

3.D. 13. The home and community services have a mechanism to ensure that both the person served and the service provider can understand and communicate with each other.

Examples

Accents and other language issues may pose barriers to communication between the person served and the service provider. Mechanisms for nonverbal communication such as the use of a communication board or device may be necessary.

3.D. 14. Based on the scope of services, to enhance the involvement of the persons served in the community, the home and community services:

a. Are knowledgeable about the options available for:
   (1) Housing.
   (2) Transportation.
   (3) Technology.

b. In accordance with the choice of the person served, advocate for the development of options for:
   (1) Housing.
   (2) Transportation.
   (3) Technology.

Intent Statements

Whether the home and community services address housing, transportation, and technology would be guided by the scope of services provided. Many times persons served may lack knowledge of options in their area. There may be the need for the home and community services provider to assist the person served to become aware of options and resources that they will need to tap into to develop their plan for housing, transportation and/or technology. This may be needed to allow the person served to remain in his or her home and/or community, to get to and from work, and/or to participate in social activities.

3.D. 15. In accordance with the choice of the person served, the home and community services provide or arrange for financial assistance and planning that addresses:

a. Benefits planning.

b. Sustainability of services.

c. Contingency planning.

d. Education related to financial literacy.

e. Short- and long-term planning for future services, including:
   (1) Funding and supports available.
   (2) Eligibility criteria.
   (3) Range of services available.
(4) Amount of services available.
(5) Impact on continuing benefits.

Intent Statements
An in-depth financial analysis of the short and long-term costs of living independently will take into consideration both the present ability and future service needs of the person served.
In assisting an individual to live independently in the community, it is important to evaluate present and future costs associated with the living situation.

Examples
Factors to be considered include how benefits of the person served might be impacted and the potential of funding for services changing. It is important that the person served consider being responsible for his or her own finances if appropriate.

Training in financial literacy may be provided directly by the home and community services or referred to an appropriate resource in the community.

Applicable Standards
Home and Community Services that provide specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need must also meet Standards 16.–18.

3.D. 16. The home and community services address the impact of the following areas on the service delivery process for each person served:
a. Allergies.
b. Current medications, including:
   (1) Medication sensitivities and adverse reactions.
   (2) Why each medication is prescribed.
   (3) Side effects.
   (4) Drug interactions.
   (5) Implications of abrupt discontinuation of medications.
c. The etiology and anticipated course of the illness, injury, impairment, disability, or a specific age or developmental need.
d. The results of relevant diagnostic interventions.
e. The results of relevant therapeutic interventions.
f. Communication ability.
g. Fatigue.
h. Nutrition.
i. Pain.
j. Risk factors.
k. Signs and symptoms of emergent medical or psychological conditions.
l. Sleep.

Intent Statements
To ensure the safety of the persons served and determine the most appropriate and beneficial interventions, knowledge of each person’s health and medical status and history are important. This knowledge will allow the home and community services to minimize unnecessary interventions, establish an accurate baseline of health and functional status, set realistic goals, and optimize results. Whether services are provided by credentialed personnel or non-credentialed personnel, the impact of these areas on the service delivery for each person served is observed, considered, reported as applicable, and, as needed, addressed in the person-centered plan, including the involvement of additional team members as necessary.

16.b. The home and community services are aware of the effects of medications currently taken by the person served on his or her ability to participate in the services and tolerate therapeutic activity.

Examples
16.j. Risk factors might include the impact that poor diet and lack of physical exercise has on certain conditions. It might also include assessing distress levels that may be a contributing factor for suicide risk.
3.D. 17. Depending on individual needs, the home and community services provide ongoing education and training to each person served that addresses:

a. Disease management.
b. Health advocacy, including prompt communication about health issues.
c. Prevention related to:
   (1) Recurrence of the illness, injury, impairment, disability, or a specific age or developmental need.
   (2) Potential risks and complications due to the illness, injury, impairment, disability, or a specific age or developmental need.
d. Primary healthcare.
e. Utilization of healthcare resources.
f. Wellness.

Intent Statements

The ability for an individual to become engaged with wellness and management of their health issues is key to maintaining the ability to remain in home and community settings. Appropriate education and training is provided to persons based on their needs.

Examples

Persons served may take advantage of technology (computer, DVD, CDs) to become better educated or engaged with exercise programs, etc. They may need education about areas such as how to be an advocate for their needs, physician appointments, screenings and their importance, how to become active in health issues, appropriate use of emergency/urgent care, etc.

Some organizations may have employees who provide services to persons served, but these employees are not equipped to provide education or certain services to persons served and families/support systems because it is beyond the scope of their education and their role. In this case, the employees should demonstrate how they refer the education and other needs back to another applicable entity, such as the community care access center, for response.

17.b. It is important for persons served to be able to identify signs and symptoms and when it would be appropriate to contact their physician, home and community services provider, EMTs, etc. Signs and symptoms might include frequent falls, loss of consciousness, shortness of breath with chest pains, or increased inflammation of joints with inability to perform daily tasks. The sudden onset, abruptness, or increased intensity or frequency of these symptoms signal the person served to advocate for care, medications, additional services, etc.

17.e. Education on utilization of healthcare resources might include decision making related to which healthcare provider is the most appropriate to seek advice for specific health issues or how to use insurance funding most effectively to meet individual needs.

3.D. 18. The home and community services provide education on medication, as appropriate:

a. To:
   (1) Persons served.
   (2) Families/support systems.

b. That addresses:
   (1) Actions to take in an emergency.
   (2) Administration.
   (3) Dispensing.
   (4) Disposal.
   (5) Errors.
   (6) Expiration dates.
   (7) Identification, including purpose of each medication prescribed.
   (8) Implications for management of multiple medications.
   (9) Implications of abrupt discontinuation.
   (10) Indications and contraindications.
   (11) Obtaining medication.
   (12) Sharing medication.
   (13) Side effects.
   (14) Storage.

Intent Statements

Medication management in home and community settings differs from facility-based settings in which medications are controlled by pharmacists,
nurses, and physicians. The ability to assess the understanding and competency of a person served and his or her family/support system to manage medications is critical to the person’s safety, health, and well-being.

Examples

Some organizations may have employees who provide services to persons served, but these employees are not equipped to provide education or certain services to persons served and families/support systems because it is beyond the scope of their education and their role. In this case, the employees should demonstrate how they refer the education and other needs back to another applicable entity, such as the community care access center, for response.

Applicable Standards

Home and Community Services that provide respite services must also meet Standard 19.

3.D. 19. When respite services are provided somewhere other than the person’s own home, the person served brings the following with him or her, if applicable:
   a. Adaptive equipment.
   b. Assistive technology.
   c. Emergency contact information.
   d. Information on everyday routines.
   e. Information/instructions regarding any special needs.
   f. Instructions for specific healthcare procedures.
   g. Medications.
   h. Pertinent health/medical history.

Intent Statements

The ability for the respite services to create an environment that will meet the needs of the person while in that setting is critical.

19.d. In order to maintain a person-centered approach, respite services are knowledgeable about the normal routine of the person served.

Examples

19.a.–b. Depending upon the types of persons served, respite providers may need to be able to use a variety of equipment and assistive technology and may need additional training to develop those competencies. Training might be provided by the family, vendors, or other resources.

19.c.–h. A portable profile may be used to provide information.

19.e. Special needs may include nutritional/dietary needs.

Additional Resources

Associations are frequently used resources for information on regulations, accessibility, quality, development, evidence-based practices, accepted practices in the field, and regulatory. Additional resources for information include:

- National Association of Home Care and Hospice: http://www.nahc.org
- Canadian Home Care Association: http://www.cdnhomecare.ca

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Evidence of process to identify service options and gaps
- Written procedures on verification of backgrounds of personnel
- Evidence of personnel competencies
- Policies and written procedures that address all items listed in Standard 3.D.5.a.–h.
- Evidence of risk assessments for the persons served
- Evidence that technology or equipment used by persons served is functioning and used according to person-centered plan
- Evidence of person-centered plans including agreed-upon time for service delivery
- Emergency and disaster preparedness and contingency plans
Section 3.D. Home and Community Services

- Policies and written procedures to facilitate collaboration in decision making
- Evidence of education provided to persons served, families/support systems, and other stakeholders
- Individual records of the persons served
E. Case Management

Description
Case Management proactively coordinates, facilitates, and advocates for seamless service delivery for persons with impairments, activity limitations, and participation restrictions based on the following:
- Initial and ongoing assessments.
- Knowledge and awareness of care options and linkages.
- Effective and efficient use of resources.
- Individualized plans based on the needs of the persons served.
- Predicted outcomes.
- Regulatory, legislative, and financial implications.

The delivery of case management may occur in a variety of settings that include, but are not limited to, a healthcare environment, a private practice, in the workplace or in the payer community.

Applicable Standards
All organizations seeking accreditation for Case Management must meet:
- All standards in Section 1.
- Section 2.A. Standards 1.–9.
- All standards in Section 3.E.

3.E. 1. To meet the needs of the person served, case management:
   a. Identifies:
      (1) Appropriate care options and settings.
      (2) Specialty programs/services.
      (3) Appropriate disciplines/professions.
   b. Coordinates:
      (1) Appropriate care options and settings.
      (2) Specialty programs/services.
      (3) Appropriate disciplines/professions.
   c. Defines its relationships with:
      (1) Appropriate care options and settings.
      (2) Specialty programs/services.
      (3) Appropriate disciplines/professions.
   d. Establishes key communication contacts with:
      (1) Appropriate care options and settings.
      (2) Specialty programs/services.
      (3) Appropriate disciplines/professions.

3.E. 2. Case management coordinates with:
   a. The persons served.
   b. Providers of services to the persons served.
   c. Payers.
   d. Legal entities, as applicable.

3.E. 3. Case management accesses and utilizes information about:
   a. Regulations.
   b. Legislation.
   c. Financial issues.
   d. Service availability.
   e. The healthcare delivery system.

3.E. 4. Case management advocates for:
   b. Quality-focused, appropriate care.
   c. Access to appropriate services.
   d. Delivery of care.
   e. Efficient use of available resources.
   f. Outcomes measurement and management.
   g. Development of resources in the community.
Section 3.E. Case Management

h. Services that:
   (1) Are available.
   (2) Are utilized.
   (3) Minimize and/or prevent impairment.
   (4) Reduce activity limitations.
   (5) Lessen participation restrictions.
   (6) Identify environmental barriers.
   i. The safety of the persons served.

3.E. 5. Case management participates in decisions about, but not limited to:
   a. Appropriate use of a full continuum of care.
   b. Services.
   c. Equipment.
   d. Supplies.
   e. Community resources.

Examples
Case management decisions may include identifying and implementing services to help maintain skin integrity for an individual at high risk for wounds due to limited mobility, diabetes, or other conditions.

3.E. 6. Case management facilitates:
   a. Communication that:
      (1) Avoids duplication of information.
      (2) Efficiently facilitates necessary services for the persons served.
   b. Promotion of health/well-being.
   c. Identification of issues concerning benefits.
   d. Value-based care.
   e. The provision of services to:
      (1) Minimize and/or prevent impairment.
      (2) Reduce activity limitations.
      (3) Lessen participation restrictions.
      (4) Identify environmental barriers.
   f. The safety of the persons served.
   g. Independent review, as appropriate.

Intent Statements
6.g. Independent review refers to review by an independent, impartial reviewer of the services provided to the person served.

Examples
6.g. An independent review could take the form of an independent medical examination or a file review by an individual not directly involved in the case.

3.E. 7. The responsibilities of case management include:
   a. Reviewing relevant reports to facilitate assessment.
   b. Identifying resources.
   c. Integrating information on resources into:
      (1) Case management planning.
      (2) Case management implementation.
   d. Conducting assessments.
   e. Predicting outcomes.
   f. Establishing the case management plan.
   g. Participating in the establishment of the discharge/transition plan.
   h. Providing case management services.
   i. Modifying the case management plan.
   j. Recommending or ensuring that the individuals on the team change based on the needs of the person served.
   k. Achieving the predicted outcomes.
   l. Recommending or ensuring that the persons served are transferred to the most appropriate level of care, based on need.
   m. Providing education and training.
   n. Referring the persons served to other services/programs as needed.
   o. Communicating with relevant stakeholders.
   p. Participating in performance improvement activities.
Section 3.E. Case Management

3.E. 8. Either prior to or at the time of entry to case management, case management:
   a. Gathers input from the persons served about their information needs concerning case management.
   b. Has a system to respond to the stated information needs of the persons served.

Intent Statements
The surveyors will need to be able to see how it was determined what consumers want to know about case management.
During the survey, the persons served and their families will be interviewed to obtain their feedback about information shared with them by case management.

Examples
Focus groups, surveys, questionnaires, person served councils, support groups, or other mechanisms might be used to gather input from persons served about their information needs regarding case management. The system to respond to information needs may be a process that includes identifying information needs and having a process for communication that could include telephone communication, email, websites, or other electronic resources for this purpose. The system may also include a process for referring the person served to sources of information if the case management program does not have the information to address a specific information need.

3.E. 9. In order to inform the persons served about case management either prior to or at the time of initiating services, case management provides information from the performance measurement and outcomes management system to the persons served that addresses, at a minimum:
   a. The characteristics of the persons served.
   b. The number of persons served per category of individuals who share similar characteristics within a stated period of time.
   c. Satisfaction of the persons served with the services received.

Examples
There are a variety of ways that the information may be shared and which of these ways are used will depend upon the individual needs of the persons served. Some information may be written in different languages, at different reading levels, in larger print size, etc. Some information may be shared orally or through a video presentation.
9.a.–b. The characteristics of the person served may include diagnosis, impairment, activity limitations, level of participation, life role, residential information, age, or gender. Outcomes information may be categorized along one or a combination of these parameters.

3.E. 10. Initial and ongoing assessments completed by case management:
   a. Are relevant to the needs of the persons served.
   b. Predict outcomes that include:
      (1) Functional status at discharge/transition.
      (2) Disposition at discharge/transition.
      (3) Duration of services.
   c. Consider health status.
   d. Address resource needs and utilization.
   e. Address discharge/transition planning.
   f. Address the integration of available resources.
   g. Identify:
      (1) Factors facilitating the achievement of predicted outcomes.
      (2) Barriers to the achievement of predicted outcomes.
   h. Address funding sources.
   i. Identify expectations of the:
      (1) Funding source.
      (2) Employer, if appropriate.
Section 3.E. Case Management

3.E. 11. Whenever possible, case management encourages the persons to be served and/or their family/support system to visit the programs to which they are referred prior to entry to familiarize them with the:
   a. Programs.
   b. Personnel.

3.E. 12. Case management:
   a. Communicates the behavioral and cognitive needs of the persons served to the programs/services with which they interact.
   b. Verifies that the programs/services being offered can meet the behavioral and cognitive needs of the persons served.

3.E. 13. An individual plan based on the needs of each person served addresses the following:
   a. Minimizing/preventing impairment.
   b. Reducing activity limitations.
   c. Lessening participation restrictions.
   d. Environmental modifications.
   e. Predicted outcomes of case management.
   f. Estimated timeframe for case management services.
   g. Involvement of the persons served in planning.
   h. Communication with appropriate parties.
   i. Modification based on the resources of case management.
   j. A plan for discharge/transition from case management, including mechanisms for interagency coordination.

3.E. 14. Case management provides each person served with an individualized written disclosure statement that includes sufficient information to address:
   a. The scope of case management services that will be provided.
   b. The intensity of case management services that will be provided.
   c. Insurance coverage and/or payment structure.
   d. Alternative resources to address additional identified needs.

Intent Statements
The standard requires that each person be provided with individualized information that is specific to his or her situation. This information does not all have to be in one document. Each person served should have the information presented in such a way that he or she clearly understands what will be provided and for how long, what will not be provided, and what the services will cost him or her, if anything.

Examples
14.c. Examples of information shared regarding insurance coverage may be that the payer will fund only four weeks of case management and then will reassess, a co-pay is required, there is a maximum dollar amount available for case management, etc.
14.d. Examples of alternative resources may be referral to another provider of case management, referral to different funding sources, etc.

3.E. 15. The persons served have the benefit of a consistently assigned case manager.

Intent Statements
The consistency of staffing provides for continuity of services and prevents confusion of the persons served regarding the identity of their case managers. The concept of consistently assigned personnel does not exclude a system of rotation of assignments. If such a system is used, the persons served are notified before a rotation ends and are introduced to their new case manager.
Section 3.E. Case Management

3.E. 16. To ensure the achievement of predicted outcomes, the case manager for each person served:
   a. Demonstrates appropriate competencies as defined by the program.
   b. Is identified to:
      (1) The person served.
      (2) The family/support system.
   c. Has the authority to coordinate the provision of care.
   d. Is knowledgeable about the program and services being provided to the person served.
   e. Is available to interact with:
      (1) The person served.
      (2) The team of the person served.
      (3) The family/support system.
      (4) Other stakeholders.
   f. Facilitates orientation for the person served that is appropriate to the services and the outcomes predicted.
   g. Is responsible for ensuring communication with:
      (1) External sources.
      (2) Internal sources.
   h. Brings forward to the team the available financial information to facilitate decision making about the following processes:
      (1) Intake.
      (2) Assessment.
      (3) Service planning.
      (4) Service provision.
      (5) Discharge/transition planning.
      (6) Long-term follow-up.
   i. Facilitates the involvement of the person served throughout the service process.
   j. Facilitates the gathering of information to assist the organization in follow-up activities for its analysis of program performance.
   k. Ensures that discharge/transition arrangements are completed.
   l. Ensures that discharge/transition recommendations are communicated to appropriate stakeholders.
   m. Facilitates the implementation of discharge/transition recommendations.

Intent Statements

The surveyors should be able to ask the persons served and their families/support systems about these individuals and get responses that indicate that they know who is coordinating the provision of care for the person served.

Examples

16.h.(1) Financial information that might affect placement decisions for the person served during the intake process is shared with the admitting physician and any team members involved in making recommendations for placement of the person served into the program or referral to a different level of the continuum of services.

3.E. 17. Case management interacts with, facilitates, and communicates with the team providing services which:
   a. Is determined by:
      (1) The assessment.
      (2) The individual planning process.
      (3) The predicted outcomes of the person served.
      (4) The strategies utilized to achieve the outcomes predicted.
   b. Includes:
      (1) The person served.
      (2) Members of the family/support system, as appropriate.
      (3) Personnel with the competencies necessary to evaluate and facilitate the achievement of predicted outcomes in the following areas:
         (a) Behavior.
         (b) Cognition.
         (c) Communication.
         (d) Functional.
         (e) Medical.
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(f) Pain management.
(g) Physical.
(h) Psychological.
(i) Recreation and leisure.
(j) Social.
(k) Spiritual.
(l) Vocational.

c. Provides services that address:
(1) Impairments.
(2) Activity limitations.
(3) Participation restrictions.
(4) Environmental needs.
(5) The personal preferences of the person served.
(6) Identifying the characteristics of the intended discharge/transition environment.
(7) Achievement of predicted outcomes.

Intent Statements
The team composition is determined for each person served through the assessment and individual planning processes. The team is a dynamic group of individuals that may change as the person served progresses through the program. Some professionals may be active team members for the entire length of a person's involvement in the program, while other professionals may become active members of the team as the need for their services is identified.

17.c. CARF uses terminology from the World Health Organization's (WHO's) *International Classification of Functioning, Disability, and Health* (ICF). In ICF, the term *functioning* refers to all body functions, activities, and participation, while *disability* is similarly an umbrella term for impairments, activity limitations, and participation restrictions. Environmental factors, which may be facilitators or barriers, interact with all of these components. ICF offers the following definitions:

- **Body functions** are physiological functions of body systems (including psychological functions).
- **Body structures** are anatomical parts of the body such as organs, limbs, and their components.
- **Impairments** are problems in body function or structure such as a significant deviation or loss (e.g., the loss of a limb, loss of vision).
- **Activity** is the execution of a task or action by an individual.
- **Activity limitations** are difficulties an individual may have in executing activities. Activities may be limited in nature, duration, and quality (e.g., taking care of oneself or performing the activities of a job).
- **Participation** is involvement in a life situation.
- **Participation restrictions** are problems an individual may experience in involvement in life situations. Participation may be restricted in nature, duration, and quality (e.g., being employed, participating in community activities, or obtaining a driver's license).
- **Environmental factors** make up the physical, social, and attitudinal environments in which people live and conduct their lives (e.g., stairs, terrain, and climate; availability of adaptive equipment and transportation; willingness of an employer to have an injured worker return to work).

Examples

17.b.(3)(e) Medical needs might include nursing, pharmacy, or nutrition needs in addition to needs that would be addressed by a physician.

17.c. An example of how these concepts interrelate might be a personal chef who sustains a cervical spinal cord injury in a motorcycle accident. Her impairment is paralysis of all four extremities. During rehabilitation she articulates her desire to continue operating her business. Once she returns home, she chooses recipes, instructs personal assistants who perform the manual activities related to preparing, cooking, and delivering the food, and she tastes the foods as they are being prepared. Mirrors are installed in the kitchen so that she can see all food preparation. While she experiences a number of activity limitations related to her role as a personal chef, she has a high level of participation in communicating with customers, preparing the foods, and running her business. The environment of her home provides sufficient space for assistants to work with her in all aspects of her
business and her excellent reputation facilitates her continued success with customers.

17.c.(5) Although the occupational therapist has identified dressing skills as an area to be addressed in the individual plan, the person served indicates that his wife will be home with him in the mornings before she goes to work and will assist him with dressing, so he prefers to work on other areas.

The speech-language pathologist is working with the person served on a dysphagia management program and instead of eating meals in the common dining area it is the preference of the person served to eat in her room.

3.E. 18. Case management facilitates the team’s:
   a. Ongoing communication regarding the progress of the person served toward his or her predicted outcomes.
   b. Collaboration to achieve predicted outcomes.

3.E. 19. In conjunction with providers of services, case management demonstrates that the persons served make measurable progress toward accomplishment of their predicted outcomes in accordance with predicted timeframes.

Intent Statements
Predicted outcomes are actively pursued and measured on a regular basis to determine their achievement in the anticipated timeframes and/or the need for modification. If progress toward predicted outcomes is not demonstrated in the anticipated timeframes, the program identifies issues or barriers to outcomes achievement and makes appropriate modifications.

Examples
Conformance may be demonstrated through documentation in the records of the persons served as well as discussion and interviews with personnel, referral sources, payers, and the persons served.

3.E. 20. Information is made available by case management:
   a. Regarding local or regional resources for:
      (1) Support.
      (2) Advocacy.
      (3) Civil rights.
   b. To:
      (1) The persons served.
      (2) Their families/support systems.

Examples
Case management provides information to the persons served regarding voting rights and accessibility. This includes resources to obtain and receive assistance in completing voter registration applications, and who to contact with questions about accessibility to cast a ballot.

Case management provides resources to assist the person served and her spouse with information about retirement and disability supports and what their rights are concerning benefits.

3.E. 21. As appropriate, case management has information available regarding local options for:
   a. Lodging.
   b. Transportation.

3.E. 22. Discharge/transition planning is done in collaboration with:
   a. The persons served.
   b. Families/support systems.
   c. Providers in the continuum of services.
   d. Other relevant stakeholders.
3.E. 23. When there is a change in the discharge/transition plan there is a mechanism for case management to provide as much notice as possible to:
   a. The persons served.
   b. Their families/support systems.
   c. Other relevant stakeholders.

Examples
23.a.–b. The discharge plan for the person served has been to go home with her family. However, during the training process it becomes evident that the family is not prepared to meet the needs of person served at the time of discharge. The team revises its recommendation to discharge the person served to a residential program for a period of time. This change, including the rationale, is clearly communicated and explained to the person served and the family.
23.c. Relevant stakeholders could include appropriate personnel, referral sources, payers, etc.

Case management ensures that the vendor who is supplying a walker is contacted to let him know that the person’s discharge has been delayed 24 hours until his blood pressure is stable.

3.E. 24. The discharge/transition process includes recommendations for services needed to maintain or improve the outcomes achieved.

3.E. 25. There is a written discharge/transition summary for each person served that is relevant to the services that have been provided by case management.

3.E. 26. When crisis management is necessary to handle behaviors, case management demonstrates appropriate use of emergency crisis procedures.

Intent Statements
In the event that behavior escalates to create an unstable, threatening, or dangerous situation, personnel implement the appropriate emergency procedures to protect the immediate health and safety of the person served and any others who may be at risk. The surveyors should be able to determine from interviews with personnel how they would respond to behaviors of the persons served.

Examples
Emergency crisis procedures may be implemented in response to a threat of suicide, verbal aggression or physical violence toward another person or toward property, an emotional outburst, or other behavior deemed by personnel to pose an immediate risk.

3.E. 27. When services/programs used by case management use interventions to change behavior, case management verifies that the interventions promote a positive, consistent, therapeutic approach to behavior management that address:
   a. Education through modeling of socially and culturally acceptable behaviors for:
      (1) The persons served.
      (2) Families/support systems.
      (3) Members of the community with whom the persons served regularly interact.
   b. Environmental factors to enhance the socially and culturally acceptable behaviors of the persons served.
   c. Environmental modifications.
   d. Medication management.
   e. Training in the implementation of behavior management programs for:
      (1) Personnel.
      (2) Families/support systems.

Examples
27.a.(3) Members of the community with whom the person served regularly interacts might include a taxi or transportation driver who regularly drives the persons served to their vocational services location; a hair stylist or barber who regularly provides services to the persons served, or wait staff at the local coffee shop frequented by persons served.
27.c. Environmental modifications might include the use of noise-reducing materials to provide a quiet environment; the installation of flooring or carpeting in neutral solid colors; adjusting the volume of phone ringer and door bells, limiting or controlling where and when people may visit persons served, reducing stimuli such as bright sunlight or odors, and limiting exposure to equipment, appliances, substances, etc. that may pose risk to persons served.

3.E. 28. For services/programs used by case management, it verifies that when there is a need to manage behaviors, personnel, on an ongoing basis:
   a. Observe the person served.
   b. Describe the behavioral event.
   c. Understand the behavioral event:
      (1) From the perspective of the person served.
      (2) From the perspective of the family/support system.
      (3) From the perspective of personnel.
      (4) As communication on the part of the person served.
   d. Analyze the potential causes.
   e. Determine the approach, treatment, and/or supports necessary.
   f. Address the safety of:
      (1) The person served.
      (2) Other persons served.
      (3) Personnel.
      (4) The family/support system.
      (5) Other persons involved with the person served.
   g. Implement the appropriate actions.
   h. Assess the results.
   i. Share the information learned with:
      (1) The person served.
      (2) Other personnel.
      (3) The family/support system, as appropriate.

3.E. 29. Case management:
   a. Gathers information on each person served, including information on:
      (1) Changes in:
         (a) Severity of the conditions.
         (b) Comorbidity.
      (2) Mortality.
      (3) Nonmedical interruptions in the delivery of services.
   b. At least annually conducts a written analysis that addresses:
      (1) Performance in relationship to established targets for:
         (a) Changes in:
            (i) Severity of the conditions.
            (ii) Comorbidity.
         (b) Mortality.
         (c) Nonmedical interruptions in the delivery of services.
      (2) Trends.
      (3) Actions for improvement.
      (4) Results of performance improvement plans.
      (5) Necessary education of:
         (a) Persons served.
         (b) Families/support systems.
         (c) Personnel.
         (d) Others.

Intent Statements
This standard relates to the standards in Sections 1.M. Performance Measurement and Management and 1.N. Performance Improvement. In order to analyze performance it is expected that the program identifies objectives, performance indicators, and performance targets for 29.b.(1)(a)–(c).

29.a.(1)(a) Changes in the severity of the conditions refers to the conditions that necessitate services and case management. The information gathered would cover both changes from entry to discharge and from discharge to follow-up.

Examples
29.b.(5)(d) May include payers and/or other service providers.
3.E. **30.** The records of the persons served include:

- a. Identification data.
- b. Assessment information, including information on health status or a health history.
- c. The individual plan, with goals stated.
- d. Progress/reassessment documentation.
- e. Documentation of critical incidents.
- f. Discharge/transition summaries.
- g. If appropriate, referral information and medical records, including release forms.

Examples

**30.b.** In addition to the information generated through the assessment process, the health status/health history information may include information obtained from current and previous service providers and referral sources, along with information gathered from the persons served by self-report.

3.E. **31.** A written analysis of a representative sample of records of the persons served is conducted:

- a. At least annually.
- b. To include:
  - (1) Documentation completed in accordance with the organization’s policies.
  - (2) Regulatory requirements, if applicable.
  - (3) CARF documentation requirements.
- c. That includes:
  - (1) Performance in relationship to established targets for:
    - (a) Documentation completed in accordance with the organization’s policies.
    - (b) Regulatory requirements, if applicable.
  - (2) Trends.
  - (3) Actions for improvement.
  - (4) Results of performance improvement plans.
  - (5) Necessary education and training of personnel.

Intent Statements

This standard relates to the standards in Sections 1.M. Performance Measurement and Management and 1.N. Performance Improvement. In order to analyze performance it is expected that the program identifies objectives, performance indicators, and performance targets for 31.c.(1)(a)–(c).

Please refer to the Glossary for a definition of *representative sample*.

Examples

**31.b.(1)** Program personnel review and analyze a representative sample of records to determine consistent completion of record content areas, record entries in accordance with established timeframes, and review of discharge recommendations with the persons served and other stakeholders as appropriate.

**31.b.(2)** The organization identifies its key regulatory agencies and reviews and analyzes a representative sample of records of the persons served to determine if documentation meets identified requirements. Results of the analysis are used in education and training activities to facilitate compliance with regulatory obligations.

Resources

**31.b.(3)** Refer to Appendix A for identification of CARF required documentation in the records of the persons served.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Evidence of case management's role in the continuum of care
- Individual case management plans of the persons served
- Individual records of the persons served
- Procedures for referral to other resources
- Records of service referrals
- Evidence of education provided to persons served and families/support systems
- Evidence of case management-specific information gathered on each person served
- Identification of individual(s) who coordinates the provision of care
- Evidence of communication regarding the team process that includes persons served and families/support systems
- Evidence of input from the persons served regarding their information needs
- Information compiled from the information and outcomes management system that is provided to the persons served about case management
- Initial and ongoing assessments
- Individualized written disclosure statements
- Evidence of the competencies of the individuals who coordinate provision of care
- Evidence of interaction and communication by case management with the team concerning carrying out its responsibilities
- Information on local and regional resources for support, advocacy, and civil rights
- Information about local lodging and transportation options
- Evidence of approaches to managing behaviors
- Evidence of process to verify approach of services/programs used for behavior management
- Discharge/transition recommendations
- Written discharge/transition summary for each person served
- Evidence of information gathered on persons served and a written analysis conducted at least annually
- Written analysis of a representative sample of records of persons served conducted at least annually
Section 3.F. Independent Senior Living

Description
Independent senior living communities are community housing settings that may be stand-alone or part of continuums of services. Persons served may reside in apartments, cottages, or other settings in the independent senior living environment.

Independent senior living offers a culture of customer service and hospitality as well as an environment of safety and security for persons served. A philosophy of independence, engagement, and wellness guides the communications between personnel and persons served in independent senior living.

As part of the residency and service agreement, various hospitality services may be accessed by persons served, including, but not limited to, transportation, dining, housekeeping, laundry, and social and recreational activities. Dependent on the information in the written agreement between the person served and the program, persons served may pay additional fees for various services. Information on resources in the local community may also be offered to persons served. Persons served manage or make their own arrangements for management of personal care, medications, healthcare, and activities of daily living.

Applicable Standards
An organization seeking accreditation for an Independent Senior Living program must meet the following standards:

- All standards in Section 1.
- All standards in this Section 3.F.

3.F. 1. Independent senior living:
   a. Documents the following parameters regarding its scope:
      (1) Resident population.
      (2) Age range of persons served.
      (3) Housing options.
      (4) Services available, including, but not limited to:
         (a) Activities.
         (b) Dining.
         (c) Housekeeping.
         (d) Laundry.
         (e) Maintenance.
         (f) Transportation.
      (5) For each service available, identifies:
         (a) Settings.
         (b) Hours of services.
         (c) Days of services.
         (d) Frequency of services.
         (e) Fees.
   b. Shares information about the scope of services with:
      (1) Persons served.
      (2) Families/support systems, in accordance with the choices of the persons served.
      (3) Other relevant stakeholders.
      (4) The general public.
   c. Reviews the scope of services at least annually and updates it as necessary.

Intent Statements
The scope is defined at the level of the program/service and provides the persons served, families/support systems, referral sources, payers, and other relevant stakeholders with information that helps them understand what the program/service has to offer and determine whether it will meet the needs of the persons served. If the program is part of a continuum of services, the scope is defined for each program or specialty program within the continuum.

Examples
The scope of services may be located in an information packet, on the program’s website, in a handbook, or in other documentation. The scope of services provides everyone involved with the program information regarding who is served by the program, where individuals live, how the services are provided, and information related to paying fees for services.
If the independent senior living program serves only retirees or is open to all ages, such information may be included in the scope of services. Other information regarding the resident population, such as if the program is most suited to residents who are very active or those who need some help with the activities of daily living, may also be included.

Housing options may refer to floor plans such as one- and two-bedroom residences or whether cottages, town homes, or apartments are offered. Information regarding kitchens, parking, and other housing-related details may also be included.

3.F. 2. Based on the scope of the program, the program:
   a. Documents its:
      (1) Entry criteria.
      (2) Exit criteria.
   b. Shares this information with:
      (1) Persons served.
      (2) Families/support systems.
      (3) Other relevant stakeholders.

Intent Statements
The organization determines which persons are able to reside in the living environment and identifies conditions/time/events for exit.

When establishing the criteria for entry and exit, the capability of the program to provide the needed setting is considered.

3.F. 3. There is a written agreement between the independent senior living program and the person served:
   a. That is presented in an understandable format.
   b. Of which a copy is provided to the person served:
      (1) For review prior to entry to the program.
      (2) After it is signed by all appropriate parties.
   c. That is available for review by the person served.
   d. That is signed by:
      (1) The person served.
      (2) The program’s representative.
   e. That contains information regarding:
      (1) Entry:
         (a) Criteria.
         (b) Procedures.
      (2) Exit:
         (a) Criteria.
         (b) Procedures.
      (3) Scope of services that will be provided.
      (4) Fee schedule.
      (5) Responsibility for payment of fees.
      (6) Refund policies.

Intent Statements
3.d. Refer to the Glossary for the definition of person served.

3.F. 4. The program provides opportunities to orient persons served and their families/support systems to:
   a. Familiarize them with the:
      (1) Mission of the program.
      (2) Personnel.
   b. Determine their expectations.
   c. Respond to questions regarding the living environment.

Intent Statements
In many cases, initial interactions may be a deciding factor in whether individuals move to a residential setting. Processes are helpful in ensuring that there is consistency in how interactions with those who may seek residence in the program occur.

3.F. 5. A culture of customer service that guides responsiveness to persons served is demonstrated by:
   a. Leadership.
   b. Personnel throughout the program.
Examples

This type of culture may be demonstrated by how an organization responds to questions or concerns from persons served and how personnel are accessible to problem-solve with persons served in a proactive manner. A customer service policy and related education may also address practices that emphasize responsiveness.

3.F. 6. Activities are available to persons served that:
   a. Meet their interests.
   b. Align with their capabilities.
   c. Reflect their choices.
   d. Promote their personal growth.
   e. Enhance their self-image.
   f. Improve or maintain their independence whenever possible.
   g. Allow for group interaction.
   h. Allow for autonomy.
   i. Include opportunities in the local community.

Examples

Activities can include those that are offered by the program and those that are organized and implemented by committees of persons served if the program does not have activities included in its scope of services. It may be useful for an organization to identify the types of programs available and any details regarding participation. Activities may reflect interests of the entire population of persons served, rather than a single individual, to determine what is relevant for most individuals. Activities might include painting, photography programs, fashion events, expert speakers on wellness topics, a celebration of Centenarian’s Day or other observed days, computer classes, or musical performances.

3.F. 7. The program makes available:
   a. Formal and informal educational opportunities.
   b. Access to:
      (1) Computers.
      (2) The internet.
      (3) Information of interest.
      (4) Health and wellness information.
      (5) Other media.

Examples

The program supports group learning activities such as current events discussion and might invite local experts or persons served to provide lectures on art, history, music, political science, or other topic of interest to persons served. The program might schedule outings or notify persons served of events at the local community college including movies, art, music, and education.

The program may have computer and internet access on-site in a media room or concierge station for use by persons served or it may identify community resources such as the local library, recreation center, or senior center where persons served may go for instruction and to use a computer.

Information on health and wellness topics of interest might be available through the internet, books, pamphlets, presentations, a health fair hosted by the program, or attending a community health fair.

3.F. 8. Independent senior living implements communication mechanisms that address:
   a. The needs of:
      (1) The persons served.
      (2) The program.
      (3) Other stakeholders.
   b. Emergent issues.
   c. Contingency planning.
   d. Decisions made by the person served.

Intent Statements

A variety of ways to foster communication between the program, persons served, and others is important to ensuring that expectations are being met and that there is clarity about important policies, strategic issues, or other information impacting individuals. To demonstrate conformance to this standard mechanisms should include both verbal and written methods of information exchange.
Examples

Communication mechanisms may include resident associations, personnel such as service coordinators, volunteers, or personnel who serve as liaisons with individuals. Regular information sessions or meetings may be held to provide updates and opportunities for questions to be addressed. Annual reports, memos, newsletters, and other documents may also serve as an aspect of the overall communication approach.

3.F. 9. There are regular meetings between personnel and the persons served to discuss issues concerning the living environment.

Intent Statements
See the Glossary for the definition of regular.

Examples

Meetings may be held monthly, quarterly, or annually and may include town-hall meetings with person served tenants to provide an overview of scheduled repairs or renovations, updated safety procedures, new laundry equipment and how it works, information about using updated thermostats in apartments, parking lot changes, or other topics regarding the living environment. Communications might also be meetings with individual persons served or with groups of persons served such as individuals living on a certain floor of a building or neighborhood of a campus.

3.F. 10. Independent senior living educates the persons served about safety and security measures, including, but not limited to:
  a. Staffing.
  b. Surveillance systems that are used.
  c. Entry to and exit from the property.
  d. Entry to and exit from individual residences.
  e. What to do in case of an emergency.
  f. Personal security options.

Examples

Education about safety and security measures may be conducted through meetings with individuals, safety fairs, or other events to make persons served aware of related features within the organization.

10.a. Staffing could highlight the security team, their roles, their shifts, and the number of security personnel on duty at various times.

10.b. Surveillance systems could include security personnel walking through the building or patrolling the grounds as well as door sensors to prevent inappropriate entry into the organization. Education for persons served could include information about safety cameras throughout the building and who monitors them.

10.c.–d. Specific measures may be related to driving onto the campus for a gated community, announcing guests at the front desk of a building, sign-in logs, and buzzers at individual living cottages, apartments, or units.

10.e. Depending on the policies of the organization, education may address whether persons served should contact emergency responders from the local community in the event of a medical emergency.

10.f. Personal security options may include whether an individual may have alarms on their cottage or apartment, if there are emergency response devices such as pull cords in individual units, or other available options for personal security.

3.F. 11. The program provides sufficient information for the person served to understand their rights with respect to the organization’s policy regarding emergency procedures.

3.F. 12. The program offers information to the persons served about:
  a. Advance directives.
  b. Resuscitation, including:
     (1) Provision of information for making a decision.
     (2) The right to refuse resuscitation.
c. Any legal requirements related to:
   (1) Advance directives.
   (2) Resuscitation.
d. Resources available to document their decisions.

3.F. 13. The program makes current information available:
a. To the persons served.
b. To families/support systems.
c. Regarding:
   (1) Adult protective services.
   (2) Care management services.
   (3) Community service organizations.
   (4) Crisis intervention programs.
   (5) In-home services, including:
      (a) Home healthcare services.
      (b) Homemaker services.
   (6) Meal delivery services.
   (7) Specialized services unique to the population served.
   (8) Transportation options.
   (9) Wellness and health promotion.
   (10) Other services, as requested.

Intent Statements
The program is aware of resources available in the community that may assist persons served and their families/support systems.

Examples
Programs may maintain a resource library, offer participant/family education, host family council meetings, conduct town hall meetings, post information on bulletin boards or in newsletters, and/or make referrals to local agencies.

13.c.(4) May include support groups.
13.c.(5)(a) Home healthcare could include in-home services by healthcare professionals such as nurses or therapists.
13.c.(5)(b) Homemaker services could include light housekeeping, meal preparation, shopping or companion services.

13.c.(7) May include mental health services, Alzheimer’s Association, home safety evaluations, pharmacy delivery, and home modification companies.
13.c.(10) Could include services such as hospice, durable medical equipment, and hearing aids.

3.F. 14. In accordance with the choice of the person served, independent senior living implements a mechanism to make available current written emergency information for each person served that:
a. Is stored in a consistent location in individual residences.
b. Includes, as appropriate to each person served:
   (1) Advance directives.
   (2) Allergies.
   (3) Current diagnoses/conditions and history.
   (4) Emergency contact information.
   (5) Equipment and devices.
   (6) Hospital preference.
   (7) Healthcare providers, including contact information.
   (8) Immunization status.
   (9) Insurance information.
   (10) Medications.
   (11) Other relevant information.

Examples
Current emergency information that is maintained by persons served on their own, stored in a central location in their living unit, and portable is important in emergency situations. If the organization does not maintain this information on behalf of residents, it could suggest a system or structure to persons served so that this information can be organized and available, although not all residents may choose to implement the mechanism. Ways to trigger review of and updates to the emergency information could also be part of the mechanism.

The program should be prepared to discuss the mechanism it uses to make this information available. Surveyors will not need to review the
private information maintained by persons served.

3.F. 15. The program provides information on persons served contracting for outside services, including:
   a. Exploring services.
   b. Hiring services.
   c. Managing services.
   d. Information exchange with program personnel.
   e. Terminating services.

Intent Statements
If persons served contract for outside services such as personal care attendants, companions, private duty care, cleaning assistance, or other services, the program provides information to persons served to minimize potential risks associated with unknown individuals providing services to persons served.

Examples
Information offered by the program may be in the form of a newsletter, fact sheet, town hall meeting, resident council presentation, or other venue. The information could address topics such as background checks, orientation of contracted individuals to the program on issues such as emergency response and visitation policies, information exchange that should occur with program personnel should an issue or question arise, and education for the persons served regarding responsibilities related to engaging outside services.

3.F. 16. The program demonstrates efforts to maintain or improve the physical environment, including:
   a. Preventive maintenance.
   b. Cleanliness.
   c. Plans for capital improvements of property.

3.F. 17. To verify the backgrounds of all personnel, written procedures identify actions to occur:
   a. Prior to the delivery of services to the persons served or the program.
   b. At stated intervals throughout employment.
   c. In response to the information received.

Intent Statements
This standard relates to Standard 1.I.2. in Section 1. To reduce risk and ensure the safety of the persons served, the organization defines its process to verify backgrounds of all personnel and take action when appropriate. The organization has procedures in place in the event that backgrounds or credentials cannot be verified. Continued employment might be contingent upon positive verification for some positions; the organization determines when this is the case.

Examples
A housekeeper, dining server, or driver may attend orientation but may not provide direct service to the persons served until background verification is complete.

3.F. 18. The program provides training for all personnel:
   a. At:
      (1) Orientation.
      (2) Regular intervals.
   b. That includes information on:
      (1) Aging issues.
      (2) Communication of unusual occurrences regarding persons served.
      (3) Documentation and record keeping requirements of the program, as appropriate to the job.
      (4) Legal requirements affecting the program or the personnel.
      (5) Psychological issues of the persons served.
Section 3.F. Independent Senior Living

(6) Social/cultural issues of the persons served.
(7) Specific training directly related to the program.
(8) Wellness.

Examples

18.b.(2) Unusual occurrences could include difficulty walking, repeating the same questions frequently, or calling the front desk for assistance much more frequently than usual.

18.b.(3) Might include the front desk maintaining a sign-in sheet of all parties entering the properties. Maintenance might keep records of repair requests for individual residences. Transportation personnel might record drop-off and pick-up details of persons served at the local shopping mall.

18.b.(4) Legal requirements might address whether to enter an unoccupied residence, privacy requirements, or emergency response procedures when an individual is in distress.

18.b.(5) Psychological issues might include signs of depression or loneliness and understanding the grieving process when an individual dies.

18.b.(6) Social/cultural issues could include appropriate attire at meal times or addressing persons served and personnel by their full name rather than by a first name as a sign of respect.

18.b.(7) Specific training related to the program might include information related to the role of the residents’ council or various clubs that exist in the organization. It could include a history of the program and key milestone events that are important to be aware of.

18.b.(8) Training on wellness might include information on whole person wellness and how various activities and interactions with personnel may impact wellness for the persons served. The importance of personnel physical and mental wellness might also be a training topic.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Resident handbook
- Move-in packet
- Marketing brochures
- Lease
- Residency agreement
- Activities calendar
- Resident newsletter
- Safety procedures
- Tenant or Resident Bill of Rights
- Emergency information file for each person served
- Written procedures for personnel background checks
- Personnel and volunteer training schedules
G. Continuing Care Retirement Community

Description
Continuing Care Retirement Communities (CCRCs) foster a culture of independence, safety, and community. These types of communities might also be known as Life Plan Communities. They include a tiered approach to services that are offered in multiple levels of care including independent living and assisted living and/or skilled nursing care. Persons served reside in residential living settings that may include single family homes, cottages, apartments, and/or condominiums, usually on one campus.

Entry to the CCRC and the provision of services and amenities are addressed in accordance with a written agreement between the CCRC and the person served. In addition to housing, communal services may include dining, transportation, wellness activities, health services, and a range of other supportive services. The CCRC strives for seamless transitions between levels of care, balancing the preferences with the needs of the persons served. A spirit of community with a focus on wellness combine to enhance the quality of life for the persons served.

Applicable Standards
An organization seeking accreditation for a Continuing Care Retirement Community must meet the following standards:
- All standards in Section 1.
- All standards in Section 2.A.
- All standards in Section 2.B.
- Standards in Section 2.C., as applicable
- All standards in Section 2.D.
- All standards in this Section 3.G.

3.G. 1. The CCRC:
   a. Identifies the structure of its continuum, including:
      (1) What is offered on campus.
      (2) What is offered external to the main campus.
      (3) What level(s) of care is owned by the CCRC.
      (4) What level(s) of care is contracted by the CCRC.
   b. Discloses this information to prospective persons served and their families/support systems.

Intent Statements
As CCRC models continue to evolve their continuum structure, it is important to have information available regarding where and how services are provided.

3.G. 2. Marketing efforts accurately reflect the:
   a. Structure of the CCRC.
   b. Ownership/management of the CCRC.
   c. Levels of care available.

Examples
2.a. Structure might include what levels of service are offered by the CCRC, locations of the CCRC, and whether the CCRC is part of a multi-site organization or a health system.

3.G. 3. The CCRC:
   a. Defines its relationships with the components of the continuum.
   b. Defines responsibilities of the components of the continuum.
c. Identifies key communication contacts within the components of the continuum.

d. Demonstrates:
   (1) Coordination of services to meet individual needs.
   (2) Integration of services provided through interaction and feedback:
       (a) Within its own continuum.
       (b) With other service providers/systems.

Examples

3.a. CCRCs might identify whether parts of the continuum are owned and if there are contracts or collaborations in place for various components of the continuum.

3.b. Responsibilities might identify whether residents have preferred access to components of the continuum or whether a preferred access arrangement does not exist.

3.c. There might be administrators or other personnel who are the key contacts for persons served and personnel at each component of the continuum.

3.d. Managing care and transitions might include ways that services can be provided to individuals within the CCRC continuum and with other service providers that have relationships with the CCRC.

3.G. 5. To promote seamless service delivery for the persons served:

   a. The CCRC proactively communicates, coordinates, facilitates, and advocates for appropriate transitions.

   b. Exit/transition planning addresses:
      (1) Preferences of the person served.
      (2) Rhythm of daily life.
      (3) The understanding of the family/support system regarding the current status of the person served.

   (4) Expectations of the:
      (a) Person served.
      (b) Family/support system.

   (5) Spouse and/or others living with the person served.

   (6) Contingency plans.

   (7) The environment of the next component of the continuum of care.

   (8) Capability of the family/support system.

   (9) Financial resources.

   (10) Access to health services.

   (11) Transportation.

   (12) Identification of resources that are or will be involved with the person served.

   (13) Mechanisms for coordination with other resources.

   (14) Person-centered plan for each person served.

   (15) Designation of the individual(s) who will be responsible for coordination of the person-centered plan of the person served.

Intent Statements

For organizations to offer access to supportive living as the needs of persons served change over time, team communication, coordination, and facilitation of appropriate service delivery becomes increasingly important. Many aspects of service delivery planning have to come together. Providers should be prepared to discuss their various approaches to service delivery.
Examples

5.a. Transitions could be within the CCRC or to other service providers depending on the written agreement between the organization and person served.

5.b. Individuals may transition to higher levels of service or they may leave the CCRC, depending on the written agreement.

5.b.(1) Preferences might include the type of unit the person has in assisted living, or it might be a preference for a specific personal care attendant.

5.b.(2) The person served may sleep late or may be an early riser. They might prefer to have a late lunch each day.

5.b.(3) The family might benefit from information regarding the progression of dementia and the necessary supportive services for the person served in the memory support program.

5.b.(4) Expectations might be regarding the ability of the person served to continue driving, maintaining their apartment, or paying their bills without assistance.

5.b.(5) A couple who reside together might have one individual who needs to transition to the nursing center while the other spouse continues to live in the independent living apartment. Planning considers how these individuals will continue to maintain their relationship as they have never lived apart.

5.b.(6) A contingency plan might be needed if there is no nursing beds are available for a current resident. Will they receive home care until a spot becomes available?

5.b.(7) If a person served who enjoys gardening moves from a cottage to assisted living, a plan might be developed for access to a communal garden because the new environment does not offer a personal outdoor space.

5.b.(8) As the person served moves to a higher level of service, the capability of the family/support system to make decisions on behalf of the person may need to be addressed. If the capability to make decisions doesn’t exist, another plan may need to be developed.

5.b.(9) Financial resources might include how to access a benevolent fund or whether government payer sources cover needed services.

5.b.(10) When transitioning to a higher level of service or to another organization, individuals may not be able to continue using their same healthcare providers, or they may not be able to visit the same on-site clinic or pharmacy.

5.b.(11) A person served might have driven her own car to visit close friends. When the person transitions to assisted living and gives up her car, she may need to use the weekly shuttle service offered by the organization or hire a personal transportation provider.

5.b.(12) Resources could include adaptive equipment or a therapy animals to help individuals maintain independence or communicate.

5.b.(13) If resources include adaptive equipment, transition planning might include how to coordinate with a vendor regarding appropriate use and maintenance of the equipment.

5.b.(14) Information from the person-centered plan may be shared, with appropriate consent, to facilitate a smooth transition. A planning meeting with personnel and family might be conducted.

5.b.(15) An individual might be identified to the person served and other members of the team to coordinate and facilitate the transition.

3.G. The records of the persons served follow them throughout the continuum of care.

Examples

Records to foster continuity of care through transition might follow the persons served. Such records could include medications, advance directives, emergency contacts, and allergies. Relevant records might be provided to support the continuity of care at transition between levels of care, but the entire record might not follow the person served throughout their time in the community due to confidentiality or terms of their written agreements with the CCRC; for example, clinical counseling notes might be confidential, but the counselor might provide relevant history to the social worker in the health center as the person served transitions. Records of persons served might be available for reference as needed, and they might be tracked electronically or in
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Resident handbook
- Move-in packet
- Marketing brochures
- Residence and care agreement
- Activities calendar
- Resident newsletter
- Safety procedures
- Tenant or Resident Bill of Rights
- Emergency information file for each person served
- Written procedures for personnel background checks
- Personnel and volunteer training schedules
A. Dementia Care Specialty Programs

Description

A Dementia Care Specialty Program delivers services that focus on the unique and changing physical, cognitive, communication, emotional, psychosocial, behavioral, occupational, medical, palliative, educational, environmental, and leisure/recreational needs of persons with dementia. Leadership fosters a relationship-centered culture in which persons served, families/support systems, and all personnel are empowered to make decisions in partnership based on the preferences, strengths, and needs of the person served.

The program integrates services to support persons served with dementia to live their best life, including:

- Preserving dignity and personhood.
- Minimizing the impact of impairments and secondary complications.
- Maximizing participation, including wellness, quality of life, and inclusion in the community.
- Decreasing environmental barriers.
- Promoting personal safety and security.

A Dementia Care Specialty Program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. It provides access to information, services, and resources to enhance the lives of the persons served and their families/support systems, facilitate engagement in meaningful activity, promote personal health and wellness, and preserve quality of life.

The program demonstrates the commitment, capabilities, and resources to maintain itself as a specialized program for persons with dementia.

Current research and evidence inform the implementation of service delivery models and strategies.

A Dementia Care Specialty Program engages and partners with stakeholders to increase access to services by advocating for persons with dementia to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large.

A person-centered philosophy is embraced and modeled by all personnel. Caring and respectful relationships make persons served, personnel, and other stakeholders feel valued.

Applicable Standards

Programs seeking accreditation as a Dementia Care Specialty Program (DCSP) must meet the program description and all standards in this section in addition to the related program-specific standards and all applicable standards in Sections 1 and 2. DCSP accreditation may be sought in conjunction with the following programs:

- Adult Day Services
- Assisted Living
- Person-Centered Long-Term Care Community
- Home and Community Services
- Case Management
Section 4.A. Dementia Care Specialty Programs

4.A. 1. To empower the persons served with dementia to make decisions each day that are consistent with their abilities, the program, on an ongoing basis:
   a. Assesses the ability of the persons served with dementia to make decisions.
   b. Minimizes barriers to decision making by the persons served with dementia.
   c. Communicates with the persons served with dementia regarding the immediate consequences associated with choices and behaviors that pose a potential risk to their health or safety.
   d. Facilitates appropriate support for decision making by the persons served with dementia.
   e. Documents significant discussions and decisions made by the persons served with dementia in their records.

Intent Statements

While complex decisions may not always be feasible, there are more simple decisions that a person served with dementia may be able to continue to make in order to maintain quality of life. The program personnel demonstrate approaches to communicating with the person served in a manner that clarifies his or her decision-making capacity because it can fluctuate over time, including at different times of the day.

Examples

1.a. Assessing the ability of the persons served to make decisions at different points in the day when they may be better able to interact with care providers may occur through careful observation, communication, and documentation to determine what cognitive patterns may be occurring.

1.e. This could include decisions that impact the person-centered plan of care, decisions that come up repeatedly, and high-level decisions. Significant discussions and decisions could also be related to nutrition, social interactions, or communications with family members. It may be important to document that discussions occurred with the person served and possibly also the nature of the discussion in order to be clear among caregivers why a specific decision was made.

4.A. 2. The environment addresses the unique needs of persons with dementia, including:
   a. Promoting the dignity and self-worth of the persons served.
   b. Maintaining the safety of the persons served.
   c. Maximizing the functioning of persons served in the following areas:
      (1) Behavioral.
      (2) Cognitive.
      (3) Mobility.
      (4) Occupational.
      (5) Physical.
      (6) Sensory.
      (7) Social.
   d. Optimizing their independence.

Intent Statements

2.c.(6) Providing appropriate sensory stimulation for persons with Alzheimer’s disease and other forms of dementia has been shown to decrease agitation and restlessness as well as improve sleep. Sensory stimulation translates to improved quality of life for both the person served and the caregivers. Sensory stimulation uses everyday objects to arouse one or more of the five senses (sight, smell, hearing, taste, and touch), with the goal of evoking positive feelings.

Examples

2.c.(6) Sensory stimulation activities might include:

- Talking and reading aloud to the person served.
- Giving a hand massage.
- Providing a change of scenery by taking the person outdoors or going for a short walk.
- Bringing in objects the person does not normally have around, such as sand, seashells, or other items.
Depending on how the person served reacts, the person providing services might alter the activity or switch to a different sense to find stimuli that inspire a response.

4.A. 3. The ongoing screening/assessment process includes information about the person’s:
   a. Life history.
   b. Important memories.
   c. Favorite stories.
   d. Daily routines.
   e. Comfort/reminiscence objects.
   f. People of importance.

Intent Statements
This standard supplements Standard 2.A.13. on initial and ongoing written screenings/assessments of the persons served. By using a person-centered approach to screening/assessment the program gains an understanding of the person living with dementia, including his or her values, beliefs, interests, abilities, likes and dislikes, etc., and uses this information to inform the person-centered plan addressed in Standard 2.A.14. As a person’s dementia progresses, an ongoing process for screening/assessment provides information on changing needs and preferences.

Examples
3.a. Life history may be gathered over time through a variety of techniques, including guided questions during a one-on-one conversation; observation; and information taken from group activities using photographs, music, food, or other items that might spark conversation. Information gathered might include accomplishments, losses, significant experiences, hopes, dreams, preferences, important roles, and ways of dealing with previous challenges or stressful situations. Understanding the whole person in this way provides greater understanding and appreciation of the person served and his or her life experiences and promotes dignity and respect.

3.f. People of importance may include extended family such as nieces, nephews, grandchildren, and others such as friends, neighbors, and individuals from the person’s spiritual community. People of importance may also include significant others/life partners as individuals may or may not wish to publicly identify as a member of the LGBTQ community.

Resources
- Person-Centered Assessment and Care Planning: https://academic.oup.com/gerontologist/article/58/suppl_1/S32/4816742

4.A. 4. The program provides or arranges for education:
   a. To the persons served.
   b. To families/support systems.
   c. In accordance with identified needs that addresses, but is not limited to:
      (1) Dementia, including:
          (a) Signs and symptoms.
          (b) Progression.
          (c) Types of dementia.
          (d) Coexisting conditions.
          (e) Lived experience of dementia.
      (2) Maintaining relationships.
      (3) Skills training, including:
          (a) Activities.
          (b) Therapeutic approach to behavior.
          (c) Communication skills, including communication with:
              (i) Persons served.
              (ii) Service providers.
          (d) Caregiver self-care.
      (4) Coping with changes.
      (5) Driving.
      (6) Falls.
      (7) Incontinence.
      (8) Loss and grief.
      (9) Legal issues.
      (10) Mobility.
      (11) Palliative care.
      (12) Planning for the future.
Section 4.A. Dementia Care Specialty Programs

(13) Risk of elopement.
(14) Sexuality.
(15) Skin integrity.
(16) Community resources.
(17) Payer sources.

Examples
4.b. Education is important to assist the family/support system in its understanding of the evolving needs of a person with dementia and to address concerns related to the role of being a caregiver.
4.c.(1)(e) "Lived" experience may refer to gaining a better understanding of how an individual with dementia might be perceiving his or her surroundings and interactions with others as dementia progresses.
4.c.(3)(d) Examples of caregiver self-care may include counseling for caregiver stress reduction, online support groups to share experiences and gain insights, techniques for caregiver wellness and nutrition, respite care options, and other resources that may assist the caregiver to manage physical and mental fatigue as well as grief.
4.c.(5) Education related to driving may include identifying whether a person served is able to drive safely and awareness of how to access local resources for individuals who no longer drive, including volunteer driver programs and various forms of public transportation such as paratransit and other services.
4.c.(9) Legal issues may include education and information for persons served and their families/support systems for drafting and maintaining advance directives, do not resuscitate (DNR) orders, and powers of attorney so that the representative of the person served may facilitate service delivery in a way that reflects the wishes of the person served.
4.c.(16) Community resources might include respite care, volunteer drivers, friendly visitor programs, and pet therapy programs.
4.c.(17) Persons served and their families/support systems may not have knowledge of funding sources for various services, so the program might link individuals with local, state/provincial, or national information resources to help navigate the various funding sources for services, equipment, and specific types of care.

Resources
Resources for dementia care programs include:
- The Alzheimer Society of Canada provides information, resources, education, support, and counseling for individuals impacted by dementia: www.alzheimer.ca
- WorkSafe BC offers a publication titled Dementia: Understanding risks and preventing violence: www.worksafebcmedia.com/media/WebBooks/Dementia/index.html#welcome
- The Canadian Institute for Health Information has taken a comprehensive look at dementia in Canada and has compiled a variety of information on the complex illness and the impact on seniors, caregivers and health systems: www.cihi.ca/en/dementia-in-canada
4.b. A number of caregiver organizations offer numerous dementia-related training resources and educational materials, including:
- The National Alliance for Caregiving: www.caregiving.org
- International Alliance of Carer Organizations: https://internationalcarers.org
- Family Caregiver Alliance: www.caregiver.org
- Caregiver Action Network: www.caregiveraction.org
- Safety in Dementia: https://safetyindementia.org
4.c.(5) Various organizations offer assessment tools that may help with assessing individuals’ driving ability, including:
- http://seniordriving.aaa.com/evaluate-your-driving-ability
- www.aarp.org/auto/driver-safety/driving-tips/
4.c.(6) The following resources may be useful in addressing falls:

- The National Center for Injury Prevention and Control:
- The World Health Organization:
  [www.who.int/ageing/publications/Falls_prevention7March.pdf](http://www.who.int/ageing/publications/Falls_prevention7March.pdf)
- The British Columbia Ministry of Health Planning:
- Ontario Osteoporosis Strategy:
  [www.osteostategy.on.ca](http://www.osteostategy.on.ca)
- National Falls Prevention Resource Center:

The following resource may be useful in addressing palliative care:

- Health Quality Ontario and the Ontario Palliative Care Network:
  [www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Palliative-Care](http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Palliative-Care)

#### 4.A. 5. Personnel implement a positive, therapeutic approach to behavior.

**Intent Statements**

*Responsive behaviors* is a term that is used to describe the behaviors of people with dementia, such as agitation, wandering, or depression. The term shows how the actions, words, and gestures of people with dementia are a response to their current environment. When trying to understand the behaviors of a person served, it is important to employ a positive, therapeutic approach to respond to words, gestures, and actions that the person makes to communicate meanings, needs, and concerns. Positive therapeutic approaches are typically multidisciplinary and consider the following:

- What external factors may be influencing the behavior?
- Is the behavior a problem for the person served or for me?
- Will the “solution” cause more anxiety than the problem?

Ultimately, because a person with dementia cannot be expected to change, the idea is to accept the individual as he or she is in this moment.

**Resources**

Resources to assist with therapeutic approaches to behavior may include:

- Alzheimer Society Canada: [www.alzheimer.ca](http://www.alzheimer.ca)
- Helpguide.org: [www.helpguide.org/articles/alzheimers-dementia/alzheimers-behavior-management.htm](http://www.helpguide.org/articles/alzheimers-dementia/alzheimers-behavior-management.htm)

#### 4.A. 6. As appropriate, the program incorporates into the person-centered plan:

a. A palliative approach to care.

b. End-of-life care.

**Examples**

Families/support systems should be involved in the development of advance directives and in identifying the extent to which medical intervention is to be administered.

Whenever possible, no one dies alone. Support and presence is planned for each person served so that he or she does not die alone.

The person served and his or her family/support system are interviewed about preferences for the dying process (e.g., five wishes, music, individuals present, preparation and notification, comfort items, and spiritual needs); care planning includes these preferences.

Memorial gardens may be developed outside on organization property in remembrance of those lost.

Memorials that reflect the person may be evident throughout the organization.

Do not resuscitate (DNR) orders are known and strictly adhered to. Efforts are made to clarify issues related to a person’s end-of-life wishes to avoid any misunderstanding on the part of personnel and/or the family/support system.
Some organizations do not choose to have a memorial service, but they may provide opportunities for personnel to express their grief by supporting them so they may attend the funeral of a person served.

**Resources**

- Forget Me Not: Palliative Care for People with Dementia: [www.ncbi.nlm.nih.gov/pmc/articles/PMC2600060](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2600060)

**4.A. 7.** If the program utilizes volunteers, it provides documented, competency-based training to volunteers that addresses:

- a. Communication.
- b. Dementia.
- c. Post-incident debriefing opportunities.
- d. Therapeutic approach to behavior.

**Intent Statements**

Although volunteers can be valuable to a program, it is important to have those individuals who interact with persons served and who impact service delivery receive competency-based training. This standard would not include a volunteer who assists with projects such as letter-stuffing for a one-time fundraising event.

**Examples**

Volunteers who assist with outings might receive training on emergency procedures, communication approaches, and how to maintain safety of individuals.

**7.c.** When incidents involving a person served occur during the volunteer engagement, the organization may find it helpful to debrief with the volunteer following an incident such as a person served beginning to cry during an art activity and/or yelling for help. Debriefs might be in a quiet location, shortly after the incident, and may provide an opportunity to explain potential causes, strategies that worked and did not work, and how to manage the stress or other emotions that may have resulted from the incident.

**7.d.** Volunteers might receive competency-based training regarding sexuality topics that are important to understand and respond to therapeutically if behaviors are exhibited by persons served.

**4.A. 8.** The program manager for the dementia care specialty program:

- a. Is qualified by virtue of his or her training and experience in dementia care.
- b. Has responsibility and authority to direct:
  - (1) Resource utilization.
  - (2) Performance improvement activities.
  - (3) Program development and modification.
  - (4) Educational activities for program personnel.
  - (5) Stakeholder relationship management.
  - (6) Advocacy activities.
  - (7) The development of ongoing relationships with the community.
  - (8) Promotion of the program.

**Intent Statements**

The organization determines who is the manager for the dementia program. The manager may be an administrator, a director, or another position, and he or she could have multiple programs for which he or she has responsibility. The manager should have training and experience specific to dementia care and should demonstrate that he or she has the responsibility to direct the key functional areas identified in the standard. It is also important that the manager’s style aligns with the program’s mission. To manage relationships and conduct advocacy, communication approaches such as empathy, collaborative
problem solving, and effective listening should be demonstrated by the manager.

4.A. 9. Ongoing input to the dementia care specialty program:
   a. Is provided by a physician who:
      (1) Serves the program as at least one of the following:
          (a) Medical director.
          (b) Chair or member of a professional advisory committee.
          (c) A consultant with a formal arrangement.
          (d) Medical liaison.
      (2) Is licensed by a professional governing body.
      (3) Maintains his or her:
          (a) Licensure.
          (b) Certification.
          (c) Privileges in the organization, as applicable.
      (4) Is qualified by virtue of his or her training and experience in dementia.
      (5) Participates in active clinical practice that relates to the population served.
      (6) Demonstrates currency in medical practice concerning the persons served.
      (7) Demonstrates active learning and involvement in the professional community.
   b. Addresses, but is not limited to:
      (1) Development of ongoing relationships with the medical community.
      (2) Establishment of policies and written procedures that address health issues, including monitoring.
      (3) Performance improvement activities.

Examples

The physician providing input may be a geriatrician, neurologist, etc. who is qualified by virtue of specialized training and experience in dementia and provides input for the persons served in the dementia care specialty program.

4.A. 10. The program facilitates collaboration in decision making through:
   a. Opportunities for the sharing of information through:
      (1) Communications that are scheduled at the convenience of the family/support system.
      (2) Information exchanges.
   b. Accessible information.
   c. Timelines for the exchange of information.
   d. Determining whether the information is understood by:
      (1) The person served.
      (2) The family/support system.
      (3) Personnel.
   e. Documenting significant discussions and decisions made by the persons served in their records.

Intent Statements

Collaboration, understanding, and effective decision making that reflects the knowledge and perspectives of families/support systems, persons served, and personnel can happen only if there is a well-organized system of communication. The program should identify how the various communication systems are maintained and then referenced when decisions must be made on behalf of the person served.

Examples

10.a. To communicate with members of the family/support system who may be at a distance,
or who may be unavailable due to work demands, health limitations, or family obligations, the program may utilize various types of communication technologies to interact with families such as email, Skype, and other methods.

10.d. Information might be first shared verbally in simple, brief statements and then also provided as a written summary. To determine if someone understood the information, the communicator might review it at a later time to determine if major points were understood and if questions are outstanding. If a situation lends itself to asking for a brief explanation back in the listener’s own words, that may also be a useful strategy.

Resources

- The Alzheimer’s Society in the UK offers tips for communicating effectively with persons who have dementia at www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=130
- Alzheimer’s Association Communication and Alzheimer’s www.alz.org/help-support/caregiving/daily-care/communications

4.A. 11. As needed for families/support systems, the program provides, arranges, or assists with arrangements for services, including:

a. Advocacy education.
b. Assistive technology.
c. Community resources.
d. Counseling.
e. Emotional support.
f. Reasonable accommodations.
g. Respite.
h. Support, including, but not limited to:
   (1) Family/support system-to-family/support system.
   (2) Peer-to-peer.

Intent Statements

11.b. and 11.f. Refer to the Glossary for definitions of assistive technology and reasonable accommodations.

Examples

11.c. Community resources may include transportation to and from appointments; caregivers to accompany the person served to appointments; and services not provided by the program, which might include vision services, dental care, audiology, and nonmedical services such as shopping and personal grooming services.

Resources

11.g. Resources include:

- ARCH National Respite Network and Resource Center: https://archrespite.org
- International Short Break Association: www.isba.me

4.A. 12. Within the scope of the program, the rhythm of daily life is directed by each person served, as demonstrated by:

a. Accommodating the choices of the person served regarding the cycle of each day, including:
   (1) Bathing.
   (2) Dressing.
   (3) Eating.
   (4) Hygiene.
   (5) Oral care.
   (6) Sleeping.
   (7) Waking.
   (8) Resting.

b. Choice of clothing.
c. Choice of grooming style.
d. Each person’s choice to participate in personally meaningful customary routines, including, but not limited to:
   (1) Cleaning.
   (2) Community activities.
   (3) Contact with pets.
   (4) Cooking.
   (5) Exercise/mobility activities.
   (6) Gardening.
   (7) Hobbies.
   (8) Intimacy.
(9) Recreation.
(10) Relaxation.
(11) Social interaction.
(12) Spiritual/religious activities.

Intent Statements
The extent to which each area is considered may vary for each person served. The care team, in collaboration with the person served, strives to support the person served at the highest level of choice, well-being, and independence possible.

Examples
12.d. Personally meaningful customary routines might include:
- Reading and discussing news articles.
- Birthday and holiday recognitions.
- Trivia and word games.
- Stretching, range-of-motion, and light resistance exercises.
- Dancing.
- Reminiscing.
- Sing-alongs.

4.A. 13. When the program provides food services, it fosters independence through implementation of procedures:
   a. To manage social dynamics.
   b. That allow persons served to select:
      (1) What they want to eat.
      (2) When they want to eat.
      (3) Where they want to eat.
   c. To address necessary adaptations.
   d. That balance the choices of the persons served and their health and nutrition needs.

Intent Statements
Observation of the behaviors of the persons served and their dining experience is critical, especially if they are not able to articulate what, when, where, or with whom they want to eat.

Examples
Procedures reflect the population served in areas such as food presentation, adaptations, provision of finger foods, helping persons identify what they want to eat, and allowing persons to set the pace of eating.

13.a. To manage social dynamics, persons served might have choice regarding where in the dining space they sit in order to have a positive experience, or with whom they might dine. If some persons served cannot sit for periods of time to dine while others sit for an extended period of time, these differences might be considered in identifying where individuals dine in order to have a positive social experience.

13.b. The persons served may leave food uneaten, which may indicate that it was not what they ordered, they didn’t like the taste, it was the wrong consistency, they weren’t hungry, they weren’t seated where or with whom they wanted, there is something bothersome about the environment such as temperature or noise, they are waiting for others, or they are missing equipment such as special utensils.

13.d. Balancing independence and nutrition of persons served is important for quality of life. Individuals with dementia may experience loss of hunger, difficulty in recognizing food, and difficulty chewing or swallowing. They may also exhibit behaviors that impact dining experiences. Procedures can help to support managing all of these issues in a way that also offers choice.

4.A. 14. The organization provides documented competency-based training for personnel, as appropriate to their roles:
   a. At:
      (1) Orientation.
      (2) Regular intervals.
   b. That includes:
      (1) Dementia, including:
         (a) Signs and symptoms.
         (b) Progression.
         (c) Types of dementia.
         (d) Coexisting conditions.
         (e) Lived experience of dementia.
      (2) Delirium.
      (3) Depression.
(4) Suicide risk assessment and prevention strategies.
(5) Identifying the personal preferences of the persons served.
(6) Loss and grief.
(7) Communication.
(8) Therapeutic approach to behavior.
(9) Observation skills.
(10) Sexuality.
(11) Skin integrity.
(12) Meaningful engagement of persons served on an ongoing basis.
(13) Therapeutic approach to activity development and implementation.
(14) Gathering information about the person served in the following areas:
   (a) Life history.
   (b) Important memories.
   (c) Favorite stories.
   (d) Daily routines.
   (e) Comfort/reminiscence objects.
   (f) People of importance.
(15) Advocacy.
(16) Teamwork.
(17) Pain.
(18) Palliative approach to care.
(19) End-of-life care.
(20) Hospice.

Intent Statements

14.b.(12) Almost every interaction in daily routines offers opportunities for meaningful engagement and activity-based care. Personnel are trained to actively seek opportunities, both planned and spontaneous, to engage in meaningful and purposeful interaction with the persons served.

Examples

14.b.(4) Identifying persons served in distress or exhibiting self-injurious behavior is part of ensuring that individuals receive the care and support needed to prevent suicide. Approaches might include teaching personnel about warning signs, screening protocols, and care approaches including assessing the environment to reduce access to means like balconies or windows.

14.b.(13) Therapeutic service delivery approaches might integrate favorite music, favorite foods, and other types of sensory engagement.

14.b.(14) Gathering information about the person served as part of the screening/assessment process may be enhanced by other conversation and observation approaches that may also be necessary to gather and maintain current information in light of frequent changes with the person served. It may be useful to have competency-based training focus on behavior versus asking questions about each area. Gathering information using various approaches may be useful to understand the current reality of the person served along with his or her communication level.

Practices might include observing and interpreting the meaning of behaviors and key words, phrases, or sounds used by the person served and what they indicate about the person. Strategies for understanding and responding to the information shared by the person served may include validation, mirroring, distraction, redirection, and cueing.

Resources

- Canadian Hospice and Palliative Care Association: [www.chpca.net](http://www.chpca.net)
- Alzheimer Society of Toronto has a Personal Support Worker Community: [www.alzheimertoronto.org](http://www.alzheimertoronto.org)
4.A. 15. The tools used to measure satisfaction and other feedback are appropriate to elicit input from persons with dementia.

Intent Statements
Persons served with dementia comprise the largest and most vulnerable group of persons served among elders. Their inclusion in satisfaction measurement strengthens the reliability of the results and provides a more realistic view of individuals’ experience with service delivery. If the majority of persons served are systematically omitted from satisfaction measurement, the results could have questionable validity. Only those persons served who are very severely impaired should be excluded for purposes of drawing the random sample.

In satisfaction research, families and caregiver staff sometimes serve as surrogate respondents for persons served because their varying levels of dementia led some to believe that persons served could not speak for themselves. Numerous research groups worked in the 1990s to develop reliable and valid person served satisfaction tools to capture perceptions of individuals with dementia. When using a tool, programs should inquire about how the tool is designed and field-tested for use with a dementia population.

Tools for this population are often administered by an interview. The program should inquire about the interviewer training program, including whether it includes methods proven to achieve a high response rate and the level of experience of the individuals conducting interviews of persons served. Attention should be given to how interviewers are trained to interview persons with dementia, including strategies for handling challenging situations and when to discontinue an interview if a person served is nonresponsive.

4.A. 16. Within its scope of practice and expertise, the dementia care specialty program acts as a resource to the community.

Examples
The dementia care specialty program can offer valuable expertise to individuals in the local community to increase awareness of dementia topics.

Serving as a resource might include having information on a website, speaking at local events, communicating with the fire department about persons who have dementia and how this impacts emergency response, developing free flyers for the public, conducting family workshops on signs of dementia and available resources, and presenting information at local schools about signs of dementia and what they mean.

Resources
- Dementia Friendly America
  www.alz.org/professionals/first-responders
- Alzheimer’s Association First Responders
  www.dfamerica.org

4.A. 17. To advance the field of dementia care, leadership supports:

a. The program’s participation in research opportunities.

b. The provision of information about available clinical trials and other research opportunities to:
   (1) Persons served.
   (2) Families/support systems.
   (3) Personnel.

Intent Statements
It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

Examples
17.a. The leadership encourages the program to provide input on proposed regulatory changes published for a specified period or on tools proposed that would subsequently be implemented by the program once finalized.

The leadership allows the dementia care specialty program to participate in demonstration projects, investigational studies, and other research opportunities conducted by external entities.

The program is part of a larger entity that includes a research center and the leadership promotes studies related to dementia care on its research agenda.
Resources

The Alzheimer’s Association hosts TrialMatch, a free clinical studies matching service that connects individuals with Alzheimer’s, caregivers, and healthy volunteers to current studies: www.alz.org/alzheimers-dementia/research_progress/clinical-trials/why-participate

4.A. 18. Leadership demonstrates a partnership approach to person-centered dementia care through the exchange of resources and education with:
   a. Persons served.
   b. Personnel.
   c. Families/support systems.
   d. Governing board, when applicable.
   e. Other stakeholders as appropriate.

Intent Statements

18.d. Please refer to the Glossary for a definition of governing board.

4.A. 19. The program maintains knowledge of and coordination with local, regional, provincial, national, or international resources to facilitate:
   a. Specialized dementia services.
   b. Use of appropriate subspecialties.
   c. Advocacy.

Examples

19.c. Advocacy might include being involved with a professional advocacy association, inviting regulators to your program location to see how services are provided, or meeting with legislators regarding important policies impacting people with dementia and their families.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Staff training calendar with dementia-specific topics
- Screening/assessment tools
- Family workshop calendar with dementia-specific topics
- Personnel procedures on understanding and responding to behavioral communication by persons served
- Procedures regarding the use of chemical/physical restraints
- Volunteer training calendar and topic list
- Job description for the program manager of the dementia care specialty program
- Documentation of the role of the medical director or physician advisor
- Care planning meeting schedule and process for inviting families
- Procedures for personnel regarding how to understand and support the individual rhythm of the day for each person served
- Survey tools and results regarding satisfaction and other feedback from persons served
B. Stroke Specialty Program

Description

A stroke specialty program, through application of the research available to clinical practice, delivers services that focus on the unique needs of persons who have sustained a stroke, including:
- Minimizing impairments and secondary complications.
- Reducing activity limitations.
- Maximizing participation and quality of life.
- Decreasing environmental barriers.
- Preventing recurrent stroke.

The program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. A stroke specialty program assists the persons served and their families/support systems to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

A stroke specialty program partners with the persons served, families/support systems, and providers within and outside of rehabilitation throughout phases of care from emergency through community-based services. A stroke specialty program fosters an integrated system of care that optimizes prevention, recovery, adaptation, and participation.

A stroke specialty program contributes to the development of stroke systems of care by partnering with providers within and outside of rehabilitation to increase access to services by advocating for persons who have sustained a stroke to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A stroke specialty program utilizes current research and evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in stroke research.

Applicable Standards

All Stroke Specialty Programs must meet Standards 1.–20. in Section 4.B.

An organization seeking accreditation as a Stroke Specialty Program must also meet the program description and standards for at least one of the following programs:
- Adult Day Services
- Assisted Living
- Person-Centered Long-Term Care (Nursing Home) Communities
- Home and Community Services
- Case Management

All programs seeking accreditation for Assisted Living and Person-Centered Long-Term Care Community must also meet Standards 21.–24.

4.B. The stroke specialty program defines its interventions in the following areas:
- Prevention, recognition, assessment, and treatment of conditions related to stroke and its complications.
- Promotion of lifestyle changes that focus on reducing the risk factors for recurrent stroke.
- Functional independence.
- Psychological and social coping and adaptation skills.
- Community integration and participation in life roles.
- Services for families/support systems.

Intent Statements

The stroke specialty program defines its interventions so that persons served and other stakeholders can understand the scope of services provided and make informed decisions about whether participation in the program will meet their current needs.
Examples

1.a. Conditions related to stroke and its complications may include angina, anxiety, bladder dysfunction, bowel dysfunction, cardiac arrhythmias, central post-stroke pain syndrome, congestive heart failure, contracture, complex regional pain syndrome, dehydration, deconditioning, degenerative joint disease, dementia, depression, diabetes mellitus, dyslipidemia, dysphagia, emotional lability, exercise intolerance, falls and injuries, fatigue, hypertension, malnutrition, obesity, orthostatic hypotension, pneumonia, pressure ulcers, recurrent stroke, sexual dysfunction, seizure, shoulder dysfunction, sleep disturbances, spasticity/abnormal muscle tone, thromboembolic disease, urinary tract infection, and ventilatory insufficiency.

1.b. Risk factors for recurrent stroke may include hypertension, coronary disease, obesity, thromboembolic disease, smoking, diabetes mellitus, high alcohol intake, and high cholesterol. Lifestyle changes to reduce these risks might include promoting exercise and increased activity levels, smoking cessation, improved control of blood glucose levels, and diet modifications.

1.c. Interventions to address functional independence could address impairments in cognitive, memory, and language skills; balance; and motor function.

1.d. Interventions may include counseling, support groups, or individual approaches to specific situations. For example, a social coping and adaptation skill may be practicing how to ask others to speak more slowly or repeat instructions to allow the person who has had a stroke increased time to process information.

1.e. Interventions to address community integration and participation in life roles might include arranging for transportation for the person served to attend services at his or her usual place of worship or training to play golf with modified equipment. Another example is the therapeutic recreation specialist going to a restaurant with the person served and working with him or her to order food that fits in the person’s dietary parameters.

1.f. Families/support systems are integral to assisting the persons served to attain maximal function and quality of life. Services for families/support systems might include support groups and group or individual education sessions.

4.B. 2. The program facilitates collaboration with the person served and family/support system in decision making through the following:

a. Accessible information.

b. Timing for provision and exchange of information.

c. Identification of their level of understanding of the rehabilitation process.

Intent Statements

To facilitate the decision-making roles of the person served and family/support system they are given information in a way that is understandable and in sufficient time to make informed decisions.

Examples

2.c. The level of understanding of the rehabilitation process may be identified through the preadmission assessment or assessment processes, through asking the person served or family/support system to summarize discussions and decisions made in team conferences, or through verification by the case manager or care coordinator.

4.B. 3. Based on the evidence available regarding the intensity of treatment, the stroke specialty program demonstrates a systematic approach to maximizing the intensity of participation of the persons served in the rehabilitation process.

Intent Statements

In view of increasingly limited resources it is critical to maximize utilization of the time spent in therapy, within the constraints of what the person served can tolerate, by reducing barriers such as interruptions to therapy, distractions in therapy, not getting to therapy in a timely manner, etc.
4.B. Prior to the implementation of specific treatments, personnel:
   a. Provide the rationale for those treatments to the:
      (1) Person served.
      (2) Family/support system.
   b. Provide options, as appropriate, based on the feedback received.

Intent Statements
Treatments are not always self-explanatory. To increase understanding and engagement in the rehabilitation process, the persons served and families/support systems are provided with the rationale for specific treatments, including options if appropriate, before those treatments are implemented. This may range from explanations for various discipline’s interventions to specific tasks to be undertaken at a given session.

If members of the family/support system are not available prior to implementation of a specific treatment, personnel provide the information to them at the earliest possible opportunity. Likewise, in accordance with the preference of the person served, if members of the family/support system do not participate on the team they are not part of these discussions.

Examples
The person served prefers to stay awake late into the evening, so the therapy schedule begins mid-morning instead of early morning.
5.b.(1) A person served who displays behaviors in a group setting is scheduled for individual therapy sessions when no one else will be using the physical therapy gym.
5.b.(8) To accommodate the transportation resources she has available, the person served is scheduled in the afternoon so her daughter, who works in the morning, can provide her transportation to therapy sessions.
A person served has a limited number of visits that will be covered by his insurance so the case manager, in consultation with the person served and the rest of the team, establishes a schedule that will allow visits to be spread out over a longer period of time.
5.c. A person served provides feedback that he would like to modify his schedule for outpatient visits to accommodate a change in his schedule.
A person served provides feedback that she no longer needs a break between therapy sessions and would like to revise the schedule to have back-to-back sessions.

5. The schedule for each person served reflects his or her:
   a. Preferences.
   b. Needs, including:
      (1) Behavioral.
      (2) Cognitive.
      (3) Communication.
      (4) Cultural.
      (5) Developmental.
      (6) Medical.
      (7) Physical.
      (8) Resources.
      (9) Spiritual.
   c. Feedback.
   d. Choice to participate in personally meaningful activities.

6. Based on the individual needs of the persons served, the program provides or arranges for:
   a. Services to address:
      (1) Anxiety.
      (2) Aphasia and other communication disorders.
      (3) Cardiovascular status.
      (4) Cognitive function.
      (5) Comorbidities.
      (6) Continence.
      (7) Depression.
      (8) Dysphagia.
      (9) Hearing.
      (10) Hydration.
      (11) Mood disturbances.
      (12) Motor function.
      (13) Nutrition.
(14) Perceptual deficits.
(15) Sexuality and intimacy.
(16) Skin integrity.
(17) Visual deficits.
b. Health promotion.
c. Services that prevent illness.
d. Health screenings.
e. Healthcare delivery.

Intent Statements
Services may be provided directly or arranged through other providers depending upon the scope and resources of the program. The stroke specialty program should be aware of all factors necessary to determine the most appropriate and beneficial interventions for the person served.
6.e. If the program does not directly provide healthcare, it should be prepared to demonstrate to the survey team how it accesses the healthcare delivery system when needed.

Examples
6.a.(1) The program provides training in the use of relaxation techniques and other therapeutic methods and medications to manage the anxiety of the person served.
6.a.(2) Other communication disorders could include dysarthria or apraxia.
6.a.(3) Cardiovascular status could include blood pressure, lipids, congestive heart failure, atrial fibrillation, pulmonary embolism, or deconditioning.
6.a.(5) Comorbidities could include other medical conditions that are not directly related to the stroke, such as cancer or arthritis.
6.a.(6) Continence includes continence of both bladder and bowel and knowledge of any special regimens or programs to address continence.
6.a.(7) Services might include cognitive-behavioral techniques, supportive therapy, and other therapeutic methods and/or medications to manage the depression of the person served.
6.a.(10) Assessment of hydration could include monitoring for signs of dehydration or maintaining intake and output records.
6.a.(11) Mood disturbances could include lability, impulsivity, or mania.
6.a.(12) Motor function could include ataxia, balance, mobility, paresis, or spasticity.
6.a.(13) Nutrition could include weight management, special diets such as low salt or low cholesterol, monitoring for signs of malnutrition, maintaining intake records, and noting balance of foods eaten.
6.a.(14) Perceptual deficits could include unilateral neglect.
6.a.(16) Assessment of skin integrity could include regular skin checks and routine checking of skin during care such as toileting or transfers/repositioning.
6.a.(17) Visual deficits could include visual acuity and deficits such as hemianopsia or diplopia. Services might include low vision clinics, optometry, ophthalmology, and neuroophthalmology.
6.b. Health promotion could include arranging for a speaker from the American Heart Association or the American Stroke Association/National Stroke Association. It could also include encouraging or facilitating participation in wellness programs.
6.c. Providing or arranging for vaccinations is an example of services that prevent illness.
6.d. Health screenings could include breast cancer screening, colon cancer screening, oral cancer screening, bone density screening, blood sugar screening, or blood pressure screening.

4.B. 7. Based on the individual needs of the persons served, the stroke specialty program provides or arranges for resources, services, supports, and/or interventions:
a. In the following areas:
   (1) Adaptation to disability.
   (2) Aging with a disability.
   (3) Community participation, including:
      (a) Advocacy.
      (b) Fitness.
      (c) Leisure.
      (d) Socialization.
      (e) Volunteerism.
      (f) Wellness.
(4) Driving.
(5) Falls.
(6) Insight of the person served.
(7) Life roles.
(8) Nutrition.
(9) Parenting skills.
(10) Peer support.
(11) School re-entry.
(12) Spousal/significant other relations.
(13) Supervision needs.
(14) Transportation needs.
(15) Work re-entry.

b. At each of the following times:
   (1) Beginning of services.
   (2) Appropriate intervals.
   (3) Discharge/transition.

Intent Statements
While not every person served will have needs in all areas, an assessment is performed at points in time to ensure that all relevant needs are identified and addressed. The extensiveness of the assessment in each of the areas listed may vary by individual.

Examples
7.a.(3)(b) and 7.a.(14) To facilitate getting to the fitness center on weekdays the person served will need to use public transportation. The program provides contact numbers and scheduling information for several options in the community.

7.a.(6) An assessment of the insight of the person served might consider whether the person is able to identify cognitive, functional, and/or physical limitations and areas of preservation that are consistent with what members of the team, including members of the family/support system, identify. The assessment might also consider whether the person served is able to self-manage identified limitations, seeking assistance and/or resources as needed.

7.a.(7) Life roles could address the role of the person served in his or her family; e.g., as a spouse, significant other, parent, and/or sibling; as a worker; as a volunteer; or any other role relating to the person’s participation in life situations.

7.a.(12) Spousal/significant other relations might include issues related to sexuality and changes in roles within the family.

4.B. In response to the preferences of the person served, the stroke specialty program:
   a. Assesses the person’s use of complementary health approaches.
   b. Educates the person served on the efficacy and safety of interventions.
   c. Provides information and resources on integrative health, as appropriate.

Examples
According to the National Institutes of Health National Center for Complementary and Integrative Health (nccih.nih.gov/health/integrative-health), the terms complementary and alternative refer to the use of healthcare approaches developed outside of mainstream Western, or conventional, medicine. Complementary medicine is the use of a non-mainstream approach together with conventional medicine. Alternative medicine is the use of a non-mainstream approach in place of conventional medicine. Most use of non-mainstream approaches by Americans is complementary. Integrative health incorporates complementary health approaches into mainstream healthcare.

Complementary health approaches may include:
  ■ Use of natural products, such as dietary supplements.
  ■ Mind and body practices, such as acupuncture, massage therapy, meditation, movement therapies, yoga, and relaxation techniques.
  ■ Homeopathy, naturopathy, and traditional healers.

Resources
  ■ National Center for Complementary and Integrative Health (NCCIH): nccih.nih.gov
4.B. Stroke Specialty Program

The stroke specialty program addresses prevention of secondary complications.

Intent Statements
The program addresses prevention/minimization of conditions and complications related to stroke through ongoing monitoring of the status of the person served, education of the person served and the family/support system, and training in self-management of health and the potential residual effects of a stroke.

Examples
Secondary complications of stroke may include:

- Cardiovascular complications, such as issues with blood pressure management, edema, deep venous thrombosis (DVT), and pulmonary embolus.
- Deficiencies, such as dehydration; osteoporosis; and nutritional deficiencies related to swallowing difficulties, decreased appetite and intake, or inability to prepare meals.
- Deformities, such as spasticity, shoulder subluxation, joint hyperextension, and contractures.
- Infections, such as pneumonia, urinary tract infections, cellulitis, c. difficile, and osteomyelitis.
- Mood disturbances, such as anxiety and depression.
- Pain caused by complex regional pain syndrome or positional factors.
- Physical deconditioning and inactivity.
- Trauma, such as cuts, bruises, abrasions, burns, falls, fractures, tendon overuse/abuse, and decubiti.

4.B. 10. Wellness for the persons served is promoted through activities that:

a. Are based on input from the persons served.
b. Consider input from families/support systems.
c. Are purposeful.
d. Provide for daily structured and unstructured activities.
e. Promote healthy behavior.
f. Meet their interests.
g. Align with their cognitive capabilities.
h. Align with their communication capabilities.
i. Reflect their choices.
j. Promote their personal growth.
k. Enhance their self-image.
l. Improve or maintain their functional levels whenever possible.
m. Allow for social interaction.
n. Allow for autonomy.
o. Include opportunities for community integration.
p. Are documented in the individual plan for each person served.

Examples
Well-rounded wellness programming may address aspects such as physical, social, spiritual, emotional, occupational, and intellectual.
10.d. Examples of unstructured activities might include:
- A person accustomed to working nights enjoys late night movies, the radio, a good book, or time to surf the internet.
- The availability of jigsaw puzzles, crossword puzzles, games, cards, or other similar activities may encourage persons served to participate either alone or with others.
- Large print books may be available or can be obtained from a local library that visits biweekly.
- Persons served plant seasonal flowers or create an herb garden.

Resources
- International Council on Active Aging: www.icaa.cc
- National Wellness Institute: www.nationalwellness.org
- Wellness Webinar Series, Lifeways Institute on Aging: www.matherlifewaysinstituteonaging.com/category/aging-wellness/
- People with Disabilities: Living Healthy, Centers for Disease Control and Prevention: www.cdc.gov/ncbddd/disabilityandhealth/healthyliving.html

4.B. 11. To meet the needs of the persons served, the stroke specialty program demonstrates knowledge and appropriate utilization of assistive technology.

Intent Statements
Technology has an ever-increasing presence in the lives of persons served. It is important that service providers are attuned to the role and impact of technology on the lives of the persons served.

Please see the Glossary for a definition of assistive technology.

Examples
Electronic aids to daily living, emergency response systems, environmental controls, and environmental modifications could all be considered assistive technology. The assistive technology used by a person served may range from sophisticated systems prescribed, designed, and built to meet individual needs to technology that is available at retail hardware or home goods stores.

Resources
- Consortium for Handheld Technology: www.vcu.edu/partnership/pda
- Assistive technology industry associations

4.B. 12. The program educates persons served regarding the consequences associated with choices and behaviors that pose a potential risk to their health or safety.

Intent Statements
The health and safety of persons served is paramount. However, in a person-centered approach to service delivery, the preferences of the person served may take precedence over the advice of family members, providers, or others. Under these circumstances the stroke specialty program educates the persons served about the consequences associated with choices and behaviors that pose potential risks to their health and safety, providing the opportunity for the person served to make an informed decision to engage or not engage in the behavior.

Examples
The program educates the person served about the risks of choosing to:
- Continue smoking cigarettes following a stroke.
- Jogging on the side of the road despite a reduced field of vision.
- Not using a shower chair when there are known issues with balance.
- Continue using the stove when home alone despite sensory or cognitive deficits.
The stroke specialty program demonstrates how education for the persons served and families/support systems:

a. Is coordinated.
b. Is reinforced:
   (1) Throughout the rehabilitation process.
   (2) Among members of the interdisciplinary team.
c. Is age appropriate.
d. Fosters self-management.
e. Is appropriate to the needs of:
   (1) Persons served.
   (2) Families/support systems.
f. Addresses:
   (1) Accessing emergency care if necessary.
   (2) Adaptation to stroke.
   (3) Aging with a disability.
   (4) Assistive devices.
   (5) Caregiver support.
   (6) Cognition.
   (7) Communication.
   (8) Health risks.
   (9) Home modifications.
   (10) Home safety.
   (11) Hydration.
   (12) Nutrition.
   (13) Prevention of:
      (a) New conditions.
      (b) Worsening of existing conditions.
   (14) Self-advocacy.
   (15) Sexuality and intimacy.
   (16) Signs and symptoms of and response to recurring stroke.
   (17) Smoking cessation.
   (18) Specific healthcare procedures and techniques.
   (19) Swallowing problems.
   (20) Upper and lower extremity orthotics, including:
      (a) How to apply and adjust the fit.
      (b) Limb and orthotic hygiene.
      (c) Individual utilization.
      (d) Training.

Intent Statements

13.c. Age-appropriate education is tailored to the age, developmental level, and cognitive level of the person receiving it. Content and presentation are modified to meet the needs of a young child compared to a teenager, adult, or older adult.

13.d. The concept of self-management recognizes that assistance, supports, and external resources may be necessary for successful management of one’s own health.

Examples

13.f.(2) Adaptation to stroke could include education for the persons served and families/support systems on adaptation to disability, resuming sexual activity, emotional lability, and coping with confabulation.

13.f.(6) Cognition may include memory, problem solving, and executive function.

13.f.(7) Education on communication might address strategies for communicating with peers, members of the family/support system, and other care providers. Strategies for communicating with other care providers could include teaching the persons served and families to plan for conversations with providers, preparing questions, being organized, and taking their portable healthcare profile to appointments.

13.f.(8) Health risks could include cardiovascular complications, deconditioning, deficiencies, deformities, inactivity, infections, mood disturbances, pain, obesity, and trauma.

13.f.(12) Nutrition could include weight management, special diets such as low salt or low cholesterol, how to monitor for signs of dehydration or malnutrition, and how to maintain intake records.

13.f.(13) Prevention education could address anxiety, aspiration pneumonia, back pain due
to changes in ambulation, bowel and bladder issues, changes in skin integrity due to decreased sensation or from use of an orthotic, deep venous thrombosis (DVT), depression, fatigue due to deconditioning, hip/other fractures, hypertension management, nutritional disorders, obesity, signs and symptoms of myocardial infarction, osteoarthritis, osteoporosis, pressure ulcers, seizure, shoulder pain, smoking cessation, and urinary tract infection.

13.f.(16) American Stroke Association/National Stroke Association signs and symptoms of stroke are good resources for education to recognize recurrent stroke.

13.f.(18) Specific healthcare procedures could include video swallow studies, diagnostic procedures, or surgical procedures. Specific healthcare techniques are related to the individual needs of the persons served.

13.f.(20)(b) Limb hygiene includes skin integrity and the identification of pressure areas, skin breakdown, or altered fit of the orthotic due to fluctuation in the limb.

Resources
- National Stroke Association: www.stroke.org
- Canadian Stroke Best Practice Recommendations: www.strokebestpractices.ca

4.B. 14. The program provides information to the person served and family/support system about the following, as appropriate:
   a. Financial resources.
   b. Healthcare benefits, including insurance.
   c. Laws and regulations pertaining to:
      (1) Accessibility.
      (2) Education.
      (3) Health.
      (4) Rights.
      (5) Social supports.
   d. Service options available in the community.

Examples
14.c.(3) The program provides the persons served with information on the implications of state/provincial or national requirements related to payment for services to address certain health conditions.

14.d. Persons who have sustained a stroke and families/support systems may access a wide variety of services in the community throughout different phases of recovery and community integration. Stroke specialty programs throughout the continuum of services provide information that allows the persons served and their families/support systems to explore and access service options that will meet their needs and preferences. These might include respite, day care, support groups, fitness, transportation, residential options, and social services.

4.B. 15. To facilitate transition to the community, an individualized plan is established for each person served that addresses:
   a. Factors facilitating transition to the community.
   b. Barriers to transition to the community.
   c. As appropriate, identification of other resources in the community that are or will be involved with the person served.
   d. Mechanisms for coordination with other resources.

4.B. 16. Prior to the day of discharge/transition, the stroke specialty program:
   a. Develops a follow-up plan for each person served.
   b. Arranges for follow-up care, including care for persons who leave the program’s geographic service area.
   c. Designates the individual(s) who will be responsible for coordination of the follow-up plan of each person served.

Examples
16.c. Examples of individuals responsible for coordinating the follow-up plans of the person served might be the person served, a family member, a case manager, a primary care physician, or another healthcare provider.
17. The stroke specialty program demonstrates its advocacy role within the community for persons who have sustained a stroke.

Examples

The program’s efforts to build awareness and understanding in the community of the needs and interests of persons who have sustained a stroke might include:

- Providing educational workshops to community members.
- Participating in community events and initiatives, e.g., festivals and charity events such as walks/runs for a cause.
- Entering collaborations with local governments and community-based groups to enhance services.
- Promoting integrated/inclusive community events, e.g., integrated arts such as theatre and dance and community meals.

18. The stroke specialty program acts as a resource for providers throughout the phases of stroke care from emergency through community-based services regarding:

a. Evidence-based practice.
b. Development of service models and programs for persons served.
c. Outreach and support.
d. Training of personnel in stroke rehabilitation.

19. To advance the field of stroke rehabilitation, leadership supports:

a. The program’s participation in research opportunities.
b. The provision of information about available clinical trials to:
   (1) Persons served.
   (2) Families/support systems.

Intent Statements

19.a. It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

Examples

19.a. The leadership encourages the program to provide input on proposed regulatory changes published for a specified period or on tools proposed that would subsequently be implemented by the program once finalized.

The leadership allows the rehabilitation program to participate in demonstration projects, investigational studies, and other research opportunities conducted by external entities.

The program is part of a larger entity that includes a research center and the leadership promotes studies related to stroke rehabilitation on its research agenda.

Resources

- Registry and results database of clinical studies, U.S. National Institutes of Health: www.clinicaltrials.gov
- Stroke Trials Registry, Internet Stroke Center, Washington University School of Medicine: www.strokecenter.org/trials
- CenterWatch, Jobson Medical Information: www.centerwatch.com
- National Cancer Institute: http://ncccp.cancer.gov/Resources/ClinicalTrials.htm
- Patient Advocate Foundation: www.patientadvocate.org

20. The stroke specialty program:

a. Gathers follow-up information on a representative sample of the persons served, including information on:
   (1) Aspiration pneumonia.
   (2) Falls.
   (3) Falls with injuries.
   (4) Other injuries.
(5) Re-hospitalizations.
(6) Unplanned medical visits/encounters.

b. At least annually conducts a written analysis that addresses:

(1) Performance in relationship to established targets for follow-up information regarding:
   (a) Aspiration pneumonia.
   (b) Falls.
   (c) Falls with injuries.
   (d) Other injuries.
   (e) Re-hospitalizations.
   (f) Unplanned medical visits/encounters.

(2) Trends.
(3) Actions for improvement.
(4) Results of performance improvement plans.
(5) Necessary education and training of:
   (a) Persons served.
   (b) Families/support systems.
   (c) Healthcare providers.

Intent Statements

This standard relates to the standards in Sections 1.M. Performance Measurement and Management and 1.N. Performance Improvement. In order to analyze performance it is expected that the program identifies objectives, performance indicators, and performance targets for 20.b.(1)(a)–(f).

CARF does not specify the timeframe for gathering follow-up information. Timeframes will vary based on the type of program provided; e.g., inpatient, outpatient, home and community services, residential, etc.

Please see the Glossary for a definition of representative sample.

Examples

Follow up can be conducted a variety of ways including by phone; mail, email, or internet survey; at a doctor’s visit or return visit to the program, or some combination of the above, as long as the questions posed are the same regardless of the mechanism used.

20.a.(4) Other injuries include burns, cuts, and other trauma resulting from stroke or its complications.

20.a.(6) Unplanned medical visits/encounters might include visits to the emergency room or urgent care and emergent office visits to see a physician related to the stroke or its complications.

Applicable Standards

All programs seeking accreditation for Assisted Living and Person-Centered Long-Term Care Community must also meet Standards 21.–24.

4.B. 21. The organization addresses the opportunity for families/support systems to remain with the persons served 24 hours a day, if desired by both the families/support systems and the persons served and deemed appropriate by the program.

Intent Statements

The opportunity for members of the family/support system to remain with the person served is based on consideration of the desire of the person served and the family/support system and the program’s determination that it is appropriate and the physical facility is conducive to such arrangements.

Examples

The room of the person served is large enough to contain a chair that can recline into a sleeping position so that a member of the family/support system can stay with the person served while they are adjusting to a new care setting.

4.B. 22. To ensure the safety of the person served, medications prescribed for the person served at time of discharge/transition are consistent with the available resources:
   a. To obtain them.
   b. Needed to adhere to recommended administration.
Examples

Resources that might impact obtaining medications and/or adhering to recommended administration include payment sources, the availability of medication samples, caregiver support, packaging of the medications, and transportation to pick them up at the pharmacy. Similarly, language barriers, literacy, or cognitive issues on the part of the person served or caregivers may pose challenges to adhering to recommended administration.

4.B.23. Based on the individual needs of each person served, the stroke specialty program addresses at discharge/transition a plan to manage:
   a. Deconditioning.
   b. Diabetes.
   c. Hyperlipidemia.
   d. Hypertension.
   e. Physical inactivity.
   f. Stroke prophylaxis.

4.B.24. The stroke specialty program:
   a. Has indicators to measure the percentage of persons served who, at the time of discharge/transition, are in compliance with evidence-based guidelines to manage:
      (1) Diabetes.
      (2) Hyperlipidemia.
      (3) Hypertension.
      (4) Stroke prophylaxis.
   b. At least annually conducts a written analysis that addresses:
      (1) Performance in relationship to established targets for the percentage of persons served who, at the time of discharge/transition, are in compliance with evidence-based guidelines to manage:
         (a) Diabetes.
         (b) Hyperlipidemia.

Intent Statements

This standard relates to the standards in Sections 1.M. Performance Measurement and Management and 1.N. Performance Improvement. In order to analyze performance it is expected that the program identifies objectives, performance indicators, and performance targets for 24.b.(1)(a)–(d). Information would be gathered from all persons served who have been diagnosed with one or more of the conditions listed.

Examples

24.a.(1) An American Diabetes Association guideline is that persons with diabetes should receive self-management education. The stroke specialty program provides the instruction and measures its effectiveness through a post-test.
24.a.(2) An evidenced-based practice guideline states that all patients with hyperlipidemia should be prescribed a lipid lowering therapy. The program counts the number of persons with hyperlipidemia and measures how many were prescribed a lipid lowering therapy at discharge.
24.a.(3) The program measures the percentage of persons served who are compliant with specific diet/food choices at the time of discharge to assist in management of hypertension.

Resources

24.a. Evidence-based guidelines include, but are not limited to, those published by:
   - American Heart Association: www.heart.org
   - American Diabetes Association: www.diabetes.org
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Evidence of the program's definition of interventions
- Evidence of collaboration in decision making
- Individual records of the persons served
- Evidence of provision or arrangements for resources, services, supports, and/or interventions
- Evidence of prevention of secondary complications of stroke
- Documentation in individual plans of persons served of wellness activities based on input from persons served and families/support systems
- Evidence of personnel knowledge and utilization of assistive technology
- Evidence of educational efforts for the persons served and their families/support systems
- Information provided about financial resources, healthcare benefits, laws and regulations, and service options available in the community
- Individualized plans for the persons served that facilitate discharge/transition to the community
- Follow-up plans for the persons served, including designation of individual responsible for coordinating the plan
- Evidence of the program acting as a resource for providers throughout the phases of stroke care
- Evidence of follow-up information gathered on the persons served, including information on aspiration pneumonia, falls, falls with injuries, other injuries, re-hospitalizations, and unplanned medical visits/encounters, and written analysis conducted at least annually
- Information provided about clinical trials
- For inpatient or residential programs:
  - Evidence of the opportunity for families/support systems to remain with the persons served 24 hours a day
  - Written discharge/transition plans that address deconditioning, diabetes, hyperlipidemia, hypertension, physical inactivity, and stroke prophylaxis
  - Evidence of information gathered at discharge/transition about diabetes, hyperlipidemia, hypertension, and stroke prophylaxis, and written analysis conducted at least annually
APPENDIX A

Required Written Documentation

The following tables list standards that explicitly require some form of written evidence in order to achieve full conformance.

When interpreting CARF standards, the following terms always indicate the need for written evidence: policy, plan, documented, documentation, and written. Other terms may also indicate the need for specific written information.

This list of standards is not inclusive of all the documentation that will be reviewed during the survey of your organization.

**NOTE:** This appendix is available in an editable electronic format at [www.carf.org/Documentation_and_Time_Lines](http://www.carf.org/Documentation_and_Time_Lines) or through the Resources section in Customer Connect ([https://customerconnect.carf.org](https://customerconnect.carf.org)).

### Section 1. ASPIRE to Excellence®

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<tr>
<td>1.A.6.a., b.</td>
<td>Written ethical codes of conduct and written procedures to deal with allegations of violations of ethical codes</td>
</tr>
<tr>
<td>1.A.7.a.</td>
<td>For U.S. organizations receiving federal funds, policy on corporate compliance adopted by organization leadership</td>
</tr>
<tr>
<td>1.A.7.b.</td>
<td>For U.S. organizations receiving federal funds, written procedures that address exclusion of individuals and entities from federally funded healthcare programs.</td>
</tr>
<tr>
<td>1.A.7.c.(1)</td>
<td>For U.S. organizations receiving federal funds, documentation of staff member designated to serve as the organization's compliance officer</td>
</tr>
<tr>
<td>1.A.9.a.</td>
<td>Written procedures related to organizational fundraising, if applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.B. Governance</th>
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</thead>
<tbody>
<tr>
<td>1.B.1.</td>
<td>Governance policies that facilitate ethical governance, assure stakeholders that governance is active and accountable, and meet legal requirements of governance</td>
</tr>
<tr>
<td>1.B.2.</td>
<td>Governance policies regarding board selection, orientation, development, education, leadership, structure, and performance</td>
</tr>
<tr>
<td>1.B.5.</td>
<td>Governance policies addressing executive leadership development and evaluation, including a written performance review and succession plan</td>
</tr>
</tbody>
</table>
### Section 1. ASPIRE to Excellence® (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
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<tbody>
<tr>
<td>1.B.6.</td>
<td>Governance policies addressing executive compensation</td>
</tr>
<tr>
<td><strong>1.C. Strategic Planning</strong></td>
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</tr>
<tr>
<td>1.C.2.b. and c.</td>
<td>Strategic plan</td>
</tr>
<tr>
<td><strong>1.E. Legal Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>1.E.2.</td>
<td>Written procedures to guide personnel in responding to subpoenas, search warrants, investigations, and other legal action</td>
</tr>
<tr>
<td>1.E.3.</td>
<td>Policies and written procedures on records</td>
</tr>
<tr>
<td><strong>1.F. Financial Planning and Management</strong></td>
<td></td>
</tr>
<tr>
<td>1.F.2.b.(1) and b.(3)</td>
<td>Written budgets</td>
</tr>
<tr>
<td>1.F.4.e.</td>
<td>Financial solvency remediation plans, if appropriate</td>
</tr>
<tr>
<td>1.F.5.b.</td>
<td>Documented analysis of financial results</td>
</tr>
<tr>
<td>1.F.7.a.</td>
<td>Fiscal policies and written procedures including internal control practices</td>
</tr>
<tr>
<td>1.F.8.b.</td>
<td>Review of representative sample of bills of persons served, if applicable</td>
</tr>
<tr>
<td>1.F.10.</td>
<td>Annual review or audit of financial statements by an independent, authorized accountant; any recommendations that resulted from the review or audit and management’s response, if applicable</td>
</tr>
<tr>
<td>1.F.11.</td>
<td>Written procedures regarding managing funds of persons served, if applicable</td>
</tr>
<tr>
<td>1.F.12.</td>
<td>Financial audit completed within 120 days of fiscal year end</td>
</tr>
<tr>
<td>1.F.14.a.</td>
<td>Investment policy, if the organization has material investments</td>
</tr>
<tr>
<td>1.F.19.a. and b.</td>
<td>Documented capital needs assessment that addresses existing capital assets and future capital asset needs</td>
</tr>
<tr>
<td>1.F.21.a.</td>
<td>Long-range financial plan</td>
</tr>
<tr>
<td><strong>1.G. Risk Management</strong></td>
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</tr>
<tr>
<td>1.G.1.a.</td>
<td>Risk management plan</td>
</tr>
<tr>
<td>1.G.3.</td>
<td>Written procedures regarding communications that address media relations and social media</td>
</tr>
<tr>
<td>1.G.4.</td>
<td>Documented reviews of contract services, if applicable</td>
</tr>
</tbody>
</table>
### Section 1. ASPIRE to Excellence® (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
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</thead>
<tbody>
<tr>
<td><strong>1.H. Health and Safety</strong></td>
<td></td>
</tr>
<tr>
<td>1.H.2.</td>
<td>Written procedures to promote the safety of persons served and personnel</td>
</tr>
<tr>
<td>1.H.4.</td>
<td>Documentation of competency-based training in health and safety for personnel at orientation and at least annually</td>
</tr>
<tr>
<td>1.H.5.</td>
<td>Written emergency and evacuation procedures</td>
</tr>
<tr>
<td>1.H.7.c. and d.</td>
<td>Written evidence of unannounced tests of each emergency procedure, including analyses</td>
</tr>
<tr>
<td>1.H.8.</td>
<td>For programs that provide services in locations that are not owned/leased or controlled/operated by the organization, written procedures that address safety at the service delivery site for persons served and personnel</td>
</tr>
<tr>
<td>1.H.10.</td>
<td>Written procedures regarding critical incidents</td>
</tr>
<tr>
<td>1.H.11.b.</td>
<td>Written analysis of critical incidents</td>
</tr>
<tr>
<td>1.H.13.h.</td>
<td>Written emergency procedures related to transportation services</td>
</tr>
<tr>
<td>1.H.15.b.</td>
<td>External health and safety inspection reports</td>
</tr>
<tr>
<td>1.H.16.</td>
<td>Written procedures for safe handling, storage, and disposal of hazardous materials</td>
</tr>
</tbody>
</table>

**I. Workforce Development and Management**

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.I.1.</td>
<td>Documentation of the composition of the organization's workforce</td>
</tr>
<tr>
<td>1.I.3.b.</td>
<td>Written job descriptions</td>
</tr>
<tr>
<td>1.I.4.</td>
<td>Written procedures related to verification of backgrounds, credentials, and fitness for duty, if required, of the workforce</td>
</tr>
<tr>
<td>1.I.6.d.(1)</td>
<td>Policies and written procedures related to workforce engagement</td>
</tr>
<tr>
<td>1.I.8.</td>
<td>Written procedures for performance appraisals</td>
</tr>
</tbody>
</table>

**1.J. Technology**

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
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</thead>
<tbody>
<tr>
<td>1.J.2.b.</td>
<td>Technology and system plan</td>
</tr>
<tr>
<td>1.J.3.</td>
<td>Policies related to the organization's use of technology</td>
</tr>
<tr>
<td>1.J.4.b. and c.</td>
<td>Written evidence of tests of the organization's procedures for business continuity/disaster recovery, including the analysis</td>
</tr>
</tbody>
</table>
### Section 1. ASPIRE to Excellence® (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.J.5.</td>
<td>Documentation of initial and ongoing personnel training on cybersecurity and the technology used in performance of job duties</td>
</tr>
<tr>
<td>1.J.6.</td>
<td>Written procedures related to use of information and communication technologies to deliver services, and to confirm technology and/or equipment at originating and remote sites is available and functions, if applicable</td>
</tr>
</tbody>
</table>

#### 1.K. Rights of Persons Served

| 1.K.1.      | Policies on the rights of persons served |
| 1.K.3.a.    | Policy and written procedure by which persons served may make a formal complaint |
| 1.K.3.b.    | Complaint forms, if applicable |
| 1.K.3.c.    | Documentation of formal complaints |
| 1.K.4.b.    | Documented analysis of all formal complaints |

#### 1.L. Accessibility

| 1.L.2.a.    | Accessibility plan |
| 1.L.3.d.    | Documentation of requests for reasonable accommodations |

#### 1.M. Performance Measurement and Management

| 1.M.3.a.    | Performance measurement and management plan that addresses all elements listed in the standard |
| 1.M.4.      | For each program/service seeking accreditation, documented objectives and performance indicators to measure results achieved for the persons served (effectiveness) |
| 1.M.5.      | For each program/service seeking accreditation, documented objectives and performance indicators to measure experience of services received and other feedback from the persons served |
| 1.M.6.      | For each program/service seeking accreditation, documented objectives and performance indicators to measure experience of services and other feedback from other stakeholders |
| 1.M.7.      | For each program/service seeking accreditation, documented objectives and performance indicators to measure the resources used to achieve results for the persons served (efficiency) |
| 1.M.8.      | For each program/service seeking accreditation, documented objectives and performance indicators to measure service access |
| 1.M.9.      | Documented objectives and performance indicators to measure business function in priority areas determined by the organization |
### Section 1. ASPIRE to Excellence® (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.M.10.</td>
<td>Documented education and training for personnel in accordance with their roles and responsibilities for performance measurement and management</td>
</tr>
</tbody>
</table>

1. **N. Performance Improvement**

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.N.1.a.–e.</td>
<td>Documented analysis of service delivery performance</td>
</tr>
<tr>
<td>1.N.1.f.(2)</td>
<td>Action plan(s) to address improvements needed</td>
</tr>
<tr>
<td>1.N.2.a.–e.</td>
<td>Documented analysis of business function performance</td>
</tr>
<tr>
<td>1.N.2.f.(2)</td>
<td>Action plan(s) to address improvements needed</td>
</tr>
</tbody>
</table>

### Section 2. The Care Process for the Persons Served

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.A.1.a.</td>
<td>Documentation of scope of service</td>
</tr>
<tr>
<td>2.A.3.</td>
<td>Entry, transition and exit criteria</td>
</tr>
<tr>
<td>2.A.8.</td>
<td>Written procedures related to mobile unit services</td>
</tr>
<tr>
<td>2.A.10.</td>
<td>Written agreements signed by persons served and the program representative that include all items listed in the standard</td>
</tr>
<tr>
<td>2.A.12.</td>
<td>Written screenings/assessments</td>
</tr>
<tr>
<td>2.A.13.</td>
<td>Initial and ongoing written screenings/assessments</td>
</tr>
<tr>
<td>2.A.14.</td>
<td>Person-centered plans for each person served that include all items listed in the standard</td>
</tr>
<tr>
<td>2.A.22.b.</td>
<td>Documentation of discussions with the families/support systems of persons served</td>
</tr>
<tr>
<td>2.A.26.</td>
<td>Policy on the use of chemical and physical restraints</td>
</tr>
<tr>
<td>2.A.27.</td>
<td>Written procedures regarding the use of chemical or physical restraints</td>
</tr>
<tr>
<td>2.A.28.</td>
<td>Written procedures that address compliance with all applicable laws and regulations pertaining to medications and controlled substances</td>
</tr>
<tr>
<td>2.A.29.c.(1)</td>
<td>Written procedures that address medications</td>
</tr>
<tr>
<td>2.A.30.</td>
<td>Policies that address advance directives and resuscitation</td>
</tr>
<tr>
<td>2.A.34.</td>
<td>Written philosophy of health and wellness for the persons served</td>
</tr>
</tbody>
</table>
Section 2. The Care Process for the Persons Served  (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.A.35.p.</td>
<td>Documentation of activities promoting wellness for persons served evident in the person-centered plan for each person served</td>
</tr>
<tr>
<td>2.A.39.i.</td>
<td>Emergency plans that take into consideration the unique needs of persons who require respiratory management, including ventilatory assistance</td>
</tr>
<tr>
<td>2.A.41.</td>
<td>Records of persons served that include all items listed in the standard</td>
</tr>
</tbody>
</table>

2.B. Residential Communities

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.B.2.</td>
<td>Policies regarding how the program provides, arranges, or assists with arrangements for the services listed</td>
</tr>
<tr>
<td>2.B.6.a.(1)</td>
<td>Policies that address medication management/assistance</td>
</tr>
<tr>
<td>2.B.8.</td>
<td>Policies that address services arranged by the person served, pets, service animals, upkeep and maintenance of individual residences, smoking, and guests</td>
</tr>
<tr>
<td>2.B.10.</td>
<td>Policies and written procedures that allow persons served to receive visitors 24 hours a day if desired</td>
</tr>
</tbody>
</table>

2.C. Care Process for Specific Diagnostic Categories

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.C.1.e.</td>
<td>Documentation of significant discussions and decisions made by the persons served with dementia in their records</td>
</tr>
<tr>
<td>2.C.6.</td>
<td>Documented competency-based training for volunteers that includes issues related to persons served with dementia, as identified in the standard</td>
</tr>
<tr>
<td>2.C.7.</td>
<td>Documented competency-based training for personnel that includes issues related to persons served with dementia, as identified in the standard</td>
</tr>
</tbody>
</table>

2.D. Skin Integrity and Wound Care Standards

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.D.1.</td>
<td>Written procedures addressing skin integrity and wound care that include all areas listed in the standard</td>
</tr>
<tr>
<td>2.D.2.</td>
<td>Initial and ongoing assessments of each person served that document information about skin integrity, as identified in the standard</td>
</tr>
<tr>
<td>2.D.4.a.</td>
<td>Written protocols for wound care needs that are within the scope of the program, including documented initial and ongoing assessments of wounds and a plan for follow-up care</td>
</tr>
<tr>
<td>2.D.4.b.</td>
<td>Written protocols for referrals to or coordination with appropriate specialists for wound care needs that are not within the scope of the program</td>
</tr>
</tbody>
</table>
### Section 2. The Care Process for the Persons Served (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.D.7.</td>
<td>Documentation of competency-based training for personnel who provide services related to skin integrity and wound care, provided at orientation and regular intervals</td>
</tr>
<tr>
<td>2.D.8.b.</td>
<td>Written analysis of information gathered on persons served regarding performance in relationship to established targets for all areas identified in the standard</td>
</tr>
</tbody>
</table>

### Section 3. Program Specific Standards

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.A. Adult Day Services</td>
<td></td>
</tr>
<tr>
<td>3.A.2.b.</td>
<td>Documentation of the program’s role in, and use of, a continuum of care</td>
</tr>
<tr>
<td>3.A.3.</td>
<td>Calculated unit cost data</td>
</tr>
<tr>
<td>3.A.7.</td>
<td>Portable basic emergency information file</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.B. Assisted Living</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.B.1.</td>
<td>Documentation of the characteristics of the population the program can serve</td>
</tr>
<tr>
<td>3.B.6.</td>
<td>Policies that address PRN (as needed) medications</td>
</tr>
<tr>
<td>3.B.10.</td>
<td>Written indicators to measure falls and wellness</td>
</tr>
<tr>
<td>3.B.12.</td>
<td>Written procedures that address criminal background checks for personnel</td>
</tr>
<tr>
<td>3.B.14.</td>
<td>Portable basic emergency information file</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.C. Person-Centered Long-Term Care Community</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.C.1.a.–b.</td>
<td>Documented person-centered philosophy that addresses the listed areas</td>
</tr>
<tr>
<td>3.C.3.</td>
<td>Written information about the program’s specific arrangements for the listed services</td>
</tr>
<tr>
<td>3.C.6.e.</td>
<td>Documentation of discussions and decisions made by the persons served in their record</td>
</tr>
<tr>
<td>3.C.7.a.</td>
<td>Written risk assessments in the areas listed</td>
</tr>
<tr>
<td>3.C.15.</td>
<td>Policies and written procedures that address nursing services</td>
</tr>
<tr>
<td>3.C.16.</td>
<td>Policies and written procedures that address medical and rehabilitation management</td>
</tr>
</tbody>
</table>
### Section 3. Program Specific Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.C.21.</td>
<td>Written agreement with the medical director for the program that outlines his or her responsibilities</td>
</tr>
<tr>
<td>3.C.23.</td>
<td>Documented competency-based training for personnel</td>
</tr>
<tr>
<td>3.C.32.</td>
<td>Portable basic emergency information file</td>
</tr>
<tr>
<td><strong>3.D. Home and Community Services</strong></td>
<td></td>
</tr>
<tr>
<td>3.D.3.</td>
<td>Written procedures identifying actions taken to verify backgrounds of personnel</td>
</tr>
<tr>
<td>3.D.5.</td>
<td>Policies and written procedures address service delivery</td>
</tr>
<tr>
<td>3.D.8.</td>
<td>Disaster preparedness and emergency plans developed for the persons served with assistance by HCS</td>
</tr>
<tr>
<td>3.D.11.</td>
<td>Policies and written procedures facilitating collaboration with the family/support system</td>
</tr>
<tr>
<td><strong>3.E. Case Management</strong></td>
<td></td>
</tr>
<tr>
<td>3.E.13.</td>
<td>Individual plans</td>
</tr>
<tr>
<td>3.E.25.</td>
<td>Written discharge/transition summaries</td>
</tr>
<tr>
<td>3.E.29.b.</td>
<td>Written analysis of information gathered on persons served</td>
</tr>
<tr>
<td>3.E.30.</td>
<td>All records of the persons served</td>
</tr>
<tr>
<td>3.E.31.</td>
<td>Written analysis of representative sample of records of persons served</td>
</tr>
<tr>
<td><strong>3.F. Independent Senior Living</strong></td>
<td></td>
</tr>
<tr>
<td>3.F.1.a.</td>
<td>Documented parameters regarding scope of services</td>
</tr>
<tr>
<td>3.F.2.a.</td>
<td>Documented entry and exit criteria</td>
</tr>
<tr>
<td>3.F.3.</td>
<td>Written agreements signed by persons served and the program representative that include all items listed in the standard</td>
</tr>
<tr>
<td>3.F.17.</td>
<td>Written procedures for personnel background verification</td>
</tr>
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</table>
### Section 4. Specialty Population Designations

<table>
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<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.A. Dementia Care Specialty Programs</strong></td>
<td></td>
</tr>
<tr>
<td>4.A.1.e.</td>
<td>Documentation of significant discussions and decisions made by the persons served with dementia in their records</td>
</tr>
<tr>
<td>4.A.7.</td>
<td>Documented competency-based training for volunteers that includes issues related to persons served with dementia, as identified in the standard</td>
</tr>
<tr>
<td>4.A.9.b.(2)</td>
<td>Policies and written procedures that address health issues, including monitoring, established with physician input</td>
</tr>
<tr>
<td>4.A.10.e.</td>
<td>Documentation of significant discussions and decisions made by the persons served with dementia in their records</td>
</tr>
<tr>
<td>4.A.14.</td>
<td>Documented competency-based training for personnel that includes issues related to persons served with dementia, as identified in the standard</td>
</tr>
<tr>
<td><strong>4.B. Stroke Specialty Program</strong></td>
<td></td>
</tr>
<tr>
<td>4.B.10.p.</td>
<td>Documentation of activities promoting the wellness of persons served</td>
</tr>
<tr>
<td>4.B.15.</td>
<td>Individualized plans addressing transition to the community</td>
</tr>
<tr>
<td>4.B.16.a.</td>
<td>Follow-up plans developed prior to discharge/transition</td>
</tr>
<tr>
<td>4.B.20.b.</td>
<td>Written analysis of follow-up information gathered on persons served</td>
</tr>
<tr>
<td>4.B.23.</td>
<td>Written discharge/transition plans addressing deconditioning, diabetes, hyperlipidemia, hypertension, physical inactivity, and stroke prophylaxis</td>
</tr>
</tbody>
</table>
APPENDIX B

Operational Timelines

The following tables list CARF standards that require activities be conducted at specific time intervals. The documents assembled as part of survey preparation should provide evidence that these activities occur.

Standards that specify an activity be conducted at least or no less than a specific time period are listed in the table for the maximum timeframe within which they may occur. During an original survey the organization is expected to demonstrate, for standards that specify an activity be conducted on or within a specific time period (e.g., at least quarterly, at least annually), that the activity has occurred at least once within such period prior to the survey.

Standards that require a policy that includes a timeframe, such as for the reporting of complaints or recording information into the records of the persons served, are not included in this appendix. Standards that require activities be conducted on an ongoing or as needed basis are also not included here.

The timelines for the standards listed in the last table, Activities to be Conducted at a Frequency Determined by the Organization, may be influenced by various factors, such as local regulations or the needs of the organization and the persons served—e.g., verification of backgrounds, credentials, and fitness for duty of members of the workforce, or data collected about persons served at appropriate intervals during services. For these standards, you should identify the frequency at which these activities are scheduled. The surveyors will want to see evidence that you are following your identified timelines.

**NOTE:** This appendix is available in an editable electronic format at [www.carf.org/Documentation_and_Time_Lines](http://www.carf.org/Documentation_and_Time_Lines) or through the Resources section in Customer Connect ([https://customerconnect.carf.org](https://customerconnect.carf.org)).

Activities to be Conducted at Least Annually

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1. ASPIRE to Excellence®</strong></td>
<td></td>
</tr>
<tr>
<td>1.A.5.c.</td>
<td>Cultural competency and diversity plan reviewed for relevance</td>
</tr>
<tr>
<td>1.B.2.g.(3), (5)–(6)</td>
<td>Board conducts self-assessment of the entire board; written conflict-of-interest and ethical code of conduct declarations signed</td>
</tr>
<tr>
<td>1.B.5.b.(1)</td>
<td>Review of executive leadership succession plan</td>
</tr>
<tr>
<td>1.B.6.e.(6)</td>
<td>Review of executive compensation records</td>
</tr>
<tr>
<td>1.B.7.</td>
<td>Review of governance policies</td>
</tr>
<tr>
<td>1.C.2.d.</td>
<td>Strategic plan reviewed for relevance</td>
</tr>
</tbody>
</table>
## Activities to be Conducted at Least Annually (Continued)

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.F2.</td>
<td>Budgets are prepared and approved</td>
</tr>
<tr>
<td>1.F5.a.</td>
<td>Documented analysis of financial results</td>
</tr>
<tr>
<td>1.F10.</td>
<td>Review or audit of the financial statements of the organization by an independent accountant authorized by the appropriate authority, and, if applicable, any recommendations that resulted from the review or audit and management's response</td>
</tr>
<tr>
<td>1.F12.</td>
<td>Independent audit of the financial statements completed within 120 days of fiscal year end</td>
</tr>
<tr>
<td>1.F14.b.</td>
<td>Investment policy reviewed for relevance</td>
</tr>
<tr>
<td>1.F15.</td>
<td>Leadership reviews investment results in accordance with the investment policy</td>
</tr>
<tr>
<td>1.F16.b.</td>
<td>Cash management strategy reviewed for relevance</td>
</tr>
<tr>
<td>1.F21.d.</td>
<td>Long-range financial plan reviewed for relevance</td>
</tr>
<tr>
<td>1.G.1.b.(1)</td>
<td>Risk management plan reviewed for relevance</td>
</tr>
<tr>
<td>1.G.2.a.(2)</td>
<td>Review of organization's insurance package for adequacy</td>
</tr>
<tr>
<td>1.G.4.d.</td>
<td>Documented review of contracted services, if applicable</td>
</tr>
<tr>
<td>1.H.4.b.</td>
<td>Personnel receive competency-based training in health and safety practices, identification of unsafe environmental factors, emergency procedures, evacuation procedures (if appropriate), identification and reporting of critical incidents, medication management (if appropriate), reducing physical risks, and workplace violence</td>
</tr>
<tr>
<td>1.H.7.</td>
<td>Unannounced tests of each emergency procedure, including complete actual or simulated physical evacuation drills as relevant to the procedure, on each shift at all locations</td>
</tr>
<tr>
<td>1.H.11.</td>
<td>Written analysis of all critical incidents provided to or conducted by leadership</td>
</tr>
<tr>
<td>1.H.13.l.</td>
<td>If transportation services are contracted, contract reviewed against Standards 1.H.13.a.–k.</td>
</tr>
<tr>
<td>1.H.15.</td>
<td>Comprehensive external health and safety inspection conducted, resulting in a written report</td>
</tr>
<tr>
<td>1.J.4.</td>
<td>Test and analysis of the organization's procedures for business continuity and disaster recovery</td>
</tr>
<tr>
<td>1.K.2.a.(3)</td>
<td>Rights of persons served communicated to persons served who have been in the program longer than one year</td>
</tr>
<tr>
<td>1.K.4.</td>
<td>Written analysis of all formal complaints</td>
</tr>
<tr>
<td>1.L.2.b.</td>
<td>Accessibility plan reviewed for relevance</td>
</tr>
</tbody>
</table>
### Activities to be Conducted at Least Annually (Continued)

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.M.3.b.</td>
<td>Performance measurement and management plan reviewed for relevance</td>
</tr>
<tr>
<td>1.N.1.b.</td>
<td>Written analysis of service delivery performance</td>
</tr>
<tr>
<td>1.N.2.b.</td>
<td>Written analysis of business function performance</td>
</tr>
</tbody>
</table>

#### 2.A. Program/Service Structure

| 2.A.1.c.       | Reviews scope of services |
| 2.A.24.d.      | Personnel training on safety and security measures |
| 2.A.29.b.      | Competency-based training for personnel responsible for medications |

#### 2.D. Skin Integrity and Wound Care Standards

| 2.D.8.b.       | Written analysis of information gathered on persons served that includes performance in relationship to established targets for all areas listed in the standard |

#### 3.A. Adult Day Services

| 3.A.3.a.       | Unit cost data calculated at least annually as part of the budgeting process |

#### 3.C. Person-Centered Long-Term Care Community

| 3.C.30.b.      | The program annually address performance in relationship to targets for behavior, function, health, medication, nutrition, pain management, psychosocial, and recreation and leisure |

#### 3.E. Case Management

| 3.E.29.b.      | Written analysis of information gathered on persons served |
| 3.E.31.a.      | Written analysis of representative sample of records of persons served |

#### 3.F. Independent Senior Living

| 3.F.1.c.       | Annual review of scope of services |

#### 4.B. Stroke Specialty Program

| 4.B.20.b.      | Written analysis of follow-up information gathered on persons served that addresses performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, and healthcare providers |
| 4.B.24.b.      | Written analysis of discharge/transition information that addresses performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, and healthcare providers |
### Activities to be Conducted at Least Semiannually

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1. ASPIRE to Excellence</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>1.H.14.</td>
<td>Comprehensive health and safety self-inspections conducted on each shift, resulting in a written report</td>
</tr>
</tbody>
</table>

### Activities to be Conducted at Least Quarterly

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1. ASPIRE to Excellence</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>1.F.8.</td>
<td>Documented review of representative sample of bills of the persons served</td>
</tr>
</tbody>
</table>

### Activities to be Conducted at Least Monthly

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1. ASPIRE to Excellence</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>1.F.3.c.</td>
<td>Review of actual financial results</td>
</tr>
<tr>
<td>1.F.11.g.</td>
<td>If responsible for funds of the persons served, monthly account reconciliation provided to persons served</td>
</tr>
</tbody>
</table>

### Activities to be Conducted at a Frequency Determined by the Organization

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1. ASPIRE to Excellence</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>1.B.2.g.(4)</td>
<td>Periodic self-assessment of individual members of board</td>
</tr>
<tr>
<td>1.B.5.a.(1)</td>
<td>Formal written review of executive leadership performance by governance</td>
</tr>
<tr>
<td>1.F.19.c.</td>
<td>Regular review of capital needs assessment</td>
</tr>
<tr>
<td>1.H.13.b.</td>
<td>Regular review of driving records of all drivers</td>
</tr>
<tr>
<td>1.H.13.k.</td>
<td>Maintenance of vehicles owned or operated by the organization according to manufacturer's recommendations</td>
</tr>
<tr>
<td>1.I.4.c.(2)</td>
<td>Verification of workforce backgrounds, credentials, and fitness for duty throughout employment</td>
</tr>
</tbody>
</table>
### Activities to be Conducted at a Frequency Determined by the Organization (Continued)

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.I.7.c.</td>
<td>Timeframes/frequencies related to the competency assessment process</td>
</tr>
<tr>
<td>1.I.8.e.</td>
<td>Timeframes/frequencies related to the performance appraisal process</td>
</tr>
<tr>
<td><strong>2.C. Care Process for Specific Diagnostic Categories</strong></td>
<td></td>
</tr>
<tr>
<td>2.C.7.a.(2)</td>
<td>Competency-based training for personnel at regular intervals</td>
</tr>
<tr>
<td><strong>3.B. Assisted Living</strong></td>
<td></td>
</tr>
<tr>
<td>3.B.11.a.(2)</td>
<td>Personnel training at regular intervals</td>
</tr>
<tr>
<td>3.B.15.</td>
<td>Regular meetings between personnel and the persons served to discuss issues concerning the living environment</td>
</tr>
<tr>
<td><strong>3.C. Person-Centered Long-Term Care Community</strong></td>
<td></td>
</tr>
<tr>
<td>3.C.23.a.(2)</td>
<td>Competency-based training for personnel training at regular intervals</td>
</tr>
<tr>
<td><strong>3.F. Independent Senior Living</strong></td>
<td></td>
</tr>
<tr>
<td>3.F.9.</td>
<td>Regular meetings between personnel and the persons served to discuss issues concerning the living environment</td>
</tr>
<tr>
<td>3.F.18.a.(2)</td>
<td>Personnel training at regular intervals</td>
</tr>
<tr>
<td><strong>4.A. Dementia Care Specialty Programs</strong></td>
<td></td>
</tr>
<tr>
<td>4.A.14.a.(2)</td>
<td>Personnel training at regular intervals</td>
</tr>
</tbody>
</table>
# Appendix C

## Required Training

The following tables list the standards that require an organization to provide some form of education or training to personnel, persons served, and/or other stakeholders. Some standards require specifically qualified or trained personnel to provide certain services or require an organization to verify or ensure that personnel have appropriate qualifications, education, and/or training but do not require the organization to directly provide the requisite education or training. Such standards are not included in this appendix. Please contact your resource specialist with any questions.

*Note:* This appendix is available in an editable electronic format at [www.carf.org/Documentation_and_Time_Lines](https://www.carf.org/Documentation_and_Time_Lines) or through the Resources section in Customer Connect (https://customerconnect.carf.org).

### Section 1. ASPIRE to Excellence®

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.A. Leadership</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.A.6.c.</td>
<td>Education on ethical codes of conduct</td>
<td>Personnel and other stakeholders</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.A.7.d.</td>
<td>Training on corporate compliance</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.A.8.</td>
<td>Education to stay current in the field</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.A.9.b.</td>
<td>Training related to fundraising written procedures, if applicable</td>
<td>Personnel</td>
<td>No</td>
<td>Initial and ongoing</td>
</tr>
<tr>
<td>1.B. Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.B.2.b., d.</td>
<td>Board member orientation and education</td>
<td>Board members</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.F. Financial Planning and Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.F.7.b.</td>
<td>Training related to fiscal policies and written procedures</td>
<td>Appropriate personnel</td>
<td>No</td>
<td>Initial and ongoing</td>
</tr>
<tr>
<td>1.H. Health and Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.H.3.</td>
<td>Education designed to reduce identified physical risks</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.H.4.</td>
<td>Health and safety training that addresses all areas listed in the standard</td>
<td>Personnel</td>
<td>Yes</td>
<td>Orientation and at least annually</td>
</tr>
</tbody>
</table>
## Section 1. ASPIRE to Excellence® (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.H.12.b.(1)</td>
<td>Training regarding infections and communicable diseases</td>
<td>Personnel, persons served, and other stakeholders</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.H.13.g.</td>
<td>If the program provides transportation for persons served, training of drivers regarding the organization's transportation procedures and unique needs of persons served</td>
<td>Personnel with driving responsibilities</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>

### I. Workforce Development and Management

| 1.I.5.a and b. | Orientation and on-the-job training included in onboarding and engagement activities     | Personnel                                       | No               | None specified     |
| 1.I.7.f.      | Education and training included in workforce development activities                      | Personnel                                       | No               | None specified     |

### 1.J. Technology

| 1.J.5.        | Training on cybersecurity and technology used to perform job duties                      | Personnel                                       | No               | Initial and ongoing |
| 1.J.7.        | Training on equipment features, set up, use, maintenance, safety considerations, infection control, and troubleshooting | Personnel who deliver services via information and communication technologies | Yes              | None specified     |
| 1.J.8.        | Instruction and training on equipment features, set up, use, and troubleshooting        | Persons served, families/support systems, and others, as appropriate | No               | None specified     |

### 1.M. Performance Measurement and Management

| 1.M.10.       | Education and training in accordance with roles and responsibilities for performance measurement and management | Personnel                                       | No               | None specified     |
### Section 2. Care Process for the Persons Served

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.A.24.d.</td>
<td>Safety and security measures addressed in personnel training</td>
<td>Personnel</td>
<td>No</td>
<td>At least annually</td>
</tr>
<tr>
<td>2.A.29.</td>
<td>Training on medications</td>
<td>Personnel responsible for medications</td>
<td>Yes</td>
<td>Upon hire and at least annually</td>
</tr>
<tr>
<td>2.A.37.a.</td>
<td>Formal and informal educational opportunities provided or arranged for persons served</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>2.A.39.h.</td>
<td>Training related to respiratory management (if the program serves any persons who required respiratory management, including ventilatory assistance)</td>
<td>Persons served and families/support systems</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>2.A.45.</td>
<td>Education on how to recognize and respond to changing needs of the persons served</td>
<td>Personnel and volunteers</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>

#### 2.B. Residential Communities

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.B.3.c.(4)</td>
<td>Education on community resources for social services</td>
<td>Persons served</td>
<td>None specified</td>
</tr>
<tr>
<td>2.B.5.a.</td>
<td>Education regarding end-of-life choices, as needed</td>
<td>Persons served</td>
<td>None specified</td>
</tr>
</tbody>
</table>

#### 2.C. Care Process for Specific Diagnostic Categories

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.C.3.</td>
<td>Education that includes all areas listed in the standard, in accordance with identified needs</td>
<td>Persons served and families/support systems</td>
<td>No</td>
</tr>
<tr>
<td>2.C.6.</td>
<td>Training that addresses all areas listed in the standard, if the program utilizes volunteers</td>
<td>Volunteers</td>
<td>Yes</td>
</tr>
<tr>
<td>2.C.7.</td>
<td>Training for personnel that includes all areas listed in the standard, as appropriate to their roles</td>
<td>Personnel</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Section 2. Care Process for the Persons Served (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.D. Skin Integrity and Wound Care Standards</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.D.3.a.(6)</td>
<td>Education related to identified wound care needs that are within the scope of the program</td>
<td>Persons served, families/support systems, and personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>2.D.4.a.(7)</td>
<td>Education related to identified wound care needs that are within the scope of the program</td>
<td>Persons served, families/support systems, and personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>2.D.6.c.</td>
<td>Education to optimize outcomes for persons served with skin integrity and wound care needs</td>
<td>Other healthcare providers</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>2.D.7.</td>
<td>Training related to skin integrity and wound management that includes all areas listed in the standard</td>
<td>Personnel who provide services related to skin integrity and wound management</td>
<td>Yes</td>
<td>Orientation and regular intervals</td>
</tr>
</tbody>
</table>

### Section 3. Program Specific Standards

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.A. Adult Day Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.A.4.a. and 3.A.4.d.</td>
<td>Advocacy education and general education, as needed</td>
<td>Families/support systems</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td><strong>3.B. Assisted Living</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.B.11.</td>
<td>Training that addresses all areas listed in the standard, as needed and in accordance with job responsibilities</td>
<td>Personnel</td>
<td>No</td>
<td>Orientation and regular intervals</td>
</tr>
<tr>
<td><strong>3.C. Person-Centered Long-Term Care Community</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.C.6.b.</td>
<td>Education regarding consequences associated with choices and behaviors of persons served that pose a potential risk to their health or safety</td>
<td>Persons served</td>
<td>No</td>
<td>Ongoing</td>
</tr>
<tr>
<td>3.C.8.a.</td>
<td>Ongoing process to educate persons served that they have choice</td>
<td>Persons served</td>
<td>No</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
## Section 3. Program Specific Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.C.13.b.</td>
<td>Education on the efficacy and safety of interventions, in response to the preferences of the person served</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.C.15.a.</td>
<td>Education related to identified needs of persons served, addressed in policies and written procedures for nursing services</td>
<td>Nursing personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.C.22.d.</td>
<td>Education and skills development regarding team dynamics</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.C.23.</td>
<td>Training that addresses all areas listed in the standard, as appropriate</td>
<td>Personnel</td>
<td>Yes</td>
<td>Orientation and regular intervals</td>
</tr>
<tr>
<td>3.C.28.</td>
<td>Education on how to access resources on behalf of the person served</td>
<td>Families/support systems</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.C.29.</td>
<td>Education on financial assistance and planning that addresses all areas listed in the standard</td>
<td>Persons served and families/support systems</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>

### 3.D. Home and Community Services

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.D.12.</td>
<td>Education that addresses all areas listed in the standard, in accordance with identified needs</td>
<td>Persons served, families/support systems, and other relevant stakeholders</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.D.15.d.</td>
<td>Education related to financial literacy</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.D.17.</td>
<td>Education and training that addresses all areas listed in the standard, in accordance with individual needs, if applicable</td>
<td>Persons served</td>
<td>No</td>
<td>Ongoing</td>
</tr>
<tr>
<td>3.D.18.</td>
<td>Education on medication that addresses all areas listed in the standard, as appropriate</td>
<td>Persons served and families/support systems</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>

### 3.E. Case Management

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.E.27.a.</td>
<td>Education through modeling of socially and culturally acceptable behaviors</td>
<td>Persons served, families/support systems, and members of the community with whom the persons served regularly interact</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>
### Section 3. Program Specific Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.E.27.e.</td>
<td>Training in the implementation of behavior management programs</td>
<td>Personnel and families/support systems</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>

#### 3.F. Independent Senior Living

| 3.F.7.a. | Formal and informal educational opportunities are available | Persons served | No | None specified |
| 3.F.10.  | Education about safety and security measures that includes all areas listed in the standard | Persons served | No | None specified |
| 3.F.18.  | Training that includes all areas listed in the standard | Personnel | No | Orientation and regular intervals |

### Section 4. Specialty Program Designations

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.A.4.</td>
<td>Education that includes all areas listed in the standard, in accordance with identified needs</td>
<td>Persons served and families/support systems</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>4.A.7.</td>
<td>Training that addresses all areas listed in the standard, if the program utilizes volunteers</td>
<td>Volunteers</td>
<td>Yes</td>
<td>None specified</td>
</tr>
<tr>
<td>4.A.11.a.</td>
<td>Advocacy education, as needed</td>
<td>Families/support systems</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>4.A.14.</td>
<td>Training for personnel that includes all areas listed in the standard, as appropriate to their roles</td>
<td>Personnel</td>
<td>Yes</td>
<td>Orientation and regular intervals</td>
</tr>
</tbody>
</table>

#### 4.B. Stroke Specialty Program

| 4.B.8.b.    | Education on the efficacy and safety of interventions related to the use of complementary health approaches | Persons served | No | None specified |
| 4.B.12.     | Education regarding consequences associated with choices and behaviors that pose a potential risk to health or safety | Persons served | No | None specified |
### Section 4. Specialty Program Designations

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.B.13.</td>
<td>Education that addresses all areas listed in the standard</td>
<td>Persons served and families/support systems</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>
GLOSSARY

NOTE: This glossary has been prepared for use with all CARF standards manuals. Terms have been selected for definition because they are subject to a wide range of interpretation and therefore require clarification of their usage in CARF’s standards and materials. The glossary does not define practices or disciplines.

CARF has not attempted to provide definitions that will be universally applicable. Rather, the intention is to define the meanings of the terms as they are used by CARF.

These definitions apply to all programs and services seeking accreditation. In some instances, glossary terms are used differently in different standards manuals. In such cases, the applicable manual is noted in parentheses after the term heading and before the definition.

Access: Barriers or lack thereof for persons in obtaining services. May apply at the level of the individual persons served (timeliness or other barriers) or the target population for the organization.

Acquired brain injury: Acquired brain injury (ABI) is an insult to the brain that affects its structure or function, resulting in impairments of cognition, communication, physical function, or psychosocial behavior. ABI includes both traumatic and nontraumatic brain injury. Traumatic brain injuries may include open head injuries (e.g., gun shot wound, other penetrating injuries) or closed head injuries (e.g., blunt trauma, acceleration/deceleration injury, blast injury). Nontraumatic brain injuries may include those caused by strokes, nontraumatic hemorrhage (e.g., ruptured arterio-venous malformation, aneurysm), tumors, infectious diseases (e.g., encephalitis, meningitis), hypoxic injuries (e.g., asphyxiation, near drowning, anesthetic incidents, hypovolemia), metabolic disorders (e.g., insulin shock, liver or kidney disease), and toxin exposure (e.g., inhalation, ingestion). ABI does not include brain injuries that are congenital, degenerative, or induced by birth trauma.

Acquired impairment: An impairment that has occurred after the completion of the birthing process.

Acquisition: The purchase by one legal entity of some or all of the assets of another legal entity. In an acquisition, the purchasing entity may or may not assume some or all of the liabilities of the selling entity. Generally, the selling entity continues in existence.

Activities of daily living (ADL): The instructional area that addresses the daily tasks required to function in life. ADL encompass a broad range of activities, including maintaining personal hygiene, preparing meals, and managing household chores.

Activity: The execution of a task or action by an individual. (This definition is from the World Health Organization’s International Classification of Functioning, Disability, and Health [ICF].)

Activity limitations: Difficulties an individual may have in executing activities. (This definition is from the World Health Organization’s International Classification of Functioning, Disability, and Health [ICF].)

Adaptive equipment: Equipment or devices, such as wheelchairs, walkers, communication devices, adapted utensils, and raised toilet seats, that help persons perform their activities of daily living.

Adjudicated: (Behavioral Health, Child and Youth Services) Sentenced by a juvenile court or criminal court.

Administration: The act of managing or supporting management of an organization’s business affairs. Business affairs include activities such as strategic planning, financial planning, and human resources management.
**Administrative location:** Sites where the organization carries out administrative operations for the programs or services seeking accreditation and/or personnel who provide the programs or services seeking accreditation are located.

**Adolescence:** The period of life of an individual between childhood and adulthood, beginning at puberty and ending when one is legally recognized as an adult in one's state or province.

**Advance directives:** Specific instructions given by a person served to a care provider regarding the level and extent of care he or she wishes to receive. The intent is to aid competent adults and their families to plan and communicate in advance their decisions about medical treatment and the use of artificial life support. Included is the right to accept or refuse medical or surgical treatment. Includes psychiatric advance directives where allowed by law.

**Adverse events:** An untoward, undesirable, and usually unanticipated event such as a death of a person served, an employee, a volunteer, or a visitor in a provider organization. Incidents such as a fall or improper administration of medications are also considered adverse events even if there is no permanent effect on the individual or person served.

**Advocacy services:** Services that may include one or more of the following for persons with disabilities or other populations historically in need of advocacy:
- Personal advocacy: one-on-one advocacy to secure the rights of the person served.
- Systems advocacy: seeking to change a policy or practice that affects the person served.
- Legislative advocacy as permitted by law: seeking legislative enactments that would enhance the rights of and/or opportunities for the person served.
- Legal advocacy: using the judicial and quasi-judicial systems to protect the rights of the person served.
- Self-advocacy: enabling the person served to advocate on his/her own behalf.

**Affiliation:** A relationship, usually signified by a written agreement, between two organizations under the terms of which one organization agrees to provide specified services and personnel to meet the needs of the other, usually on a scheduled basis.

**Affirmative enterprises:** Operations designed and directed to create substantial economic opportunities for persons with disabilities.

**Assessment:** Process used with the person served to collect information related to his or her history and strengths, needs, abilities, and preferences in order to determine the diagnosis, appropriate services, and/or referral.

**Assistive technology:** Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase or improve functional capabilities of individuals.

**Aversive conditioning:** Procedures that are punishing, physically painful, emotionally frightening, deprivational, or put a person served at medical risk when they are used to modify behaviors.

**Behavioral health:** A category of medicine and rehabilitation that combines the areas of alcohol and other drug services, mental health, and psychosocial rehabilitation.

**Board:** See Governing board.

**Catastrophe:** A disaster or accident that immediately impacts an organization's ability to provide its programs or services or significantly impacts how the programs or services will be provided in the future.

**Child/adolescent:** An individual up to the age at which one is legally recognized as an adult according to state or provincial law.

**Commensurate wage:** A wage that is proportionate to the prevailing wage paid to experienced workers in the vicinity for essentially the same type of work. It is based on the quantity and quality of work produced by the worker with a disability compared to the work produced by experienced workers.

**Communication skills:** The instructional area that teaches the use of adaptive skills and assistive technology for accomplishing tasks such as
reading, writing, typing, managing finances, and storing and retrieving information.

**Community integration:** *(Aging Services, Child and Youth Services)* Being part of the mainstream of family and local community life, engaging in typical roles and responsibilities, and being an active and contributing member of one’s social groups, local town or area, and of society as a whole.

**Community relations plan:** *(Opioid Treatment Program)* Supports program efforts to help minimize negative impact on the community, promote peaceful coexistence, and plan for change and program growth.

**Community resources:** Services and/or assistance programs that are available to the members of a community. They commonly offer persons help to become more self-reliant, increase their social connectedness, and maintain their human rights and well being.

**Community settings:** Locations in the community that are owned or leased and under the control of another entity, organization, or agency, and where organization personnel go for the purpose of providing services to persons in those locations. Examples include: community job sites that are owned or leased by the employer(s) where the organization may provide employment supports such as job coaching, vocational evaluation, or work adjustment; school settings where services such as early intervention or prevention services may be provided during the school’s regular school, pre-school, or after-school program hours; or public or private sites such as libraries, recreational facilities, shopping malls, or museums where services such as community integration, case management, or community support may be provided.

**Comparative analysis:** The comparison of past and present data to ascertain change, or the comparison of present data to external benchmarks. Consistent data elements facilitate comparative analysis.

**Competency:** The criteria established for the adequate skills, knowledge, and capacity required to perform a specific set of job functions.

**Competency-based training:** An approach to education that focuses on the ability to demonstrate adequate skills, knowledge, and capacity to perform a specific set of job functions.

**Computer access training:** The instructional area that teaches the skills necessary to use specialized display equipment in order to operate computers. This includes evaluating the person served with large print, synthetic speech, and Braille access devices in order to perform word processing functions and other computer-related activities.

**Concurrent physician care:** Services delivered by more than one physician.

**Concurrent services:** Services delivered by multiple practitioners to the same person served during the same time period.

**Congenital impairment:** An impairment that is present at the completion of the birthing process.

**Consolidation:** The combination of two or more legal entities into a single legal entity, where the entities unite to form a new entity and the original entities cease to exist. In a consolidation, the consolidated entity has its own name and identity and acquires the assets and liabilities of the disappearing entities.

**Consumer:** The person served. When the person served is legally unable to exercise self-representation at any point in the decision-making process, person served also refers to those persons willing and able to make decisions on behalf of the person served. These individuals may include family members, significant others, legal representatives, guardians, and/or advocates, as appropriate. The organization should have a means by which a legal representative of the person served, if any, is invited to participate at appropriate points in the decision-making process. By the same token, a person who is legally able to represent his or her own interests should be granted the right to choose whether family, significant others, or advocates may participate in the decision-making process. In standards that deal with infants, children, and/or adolescents, the family may be referenced directly as the family may serve as a person served in such situations.
Continuum of care/Continuum of services: A system of services addressing the ongoing and/or intermittent needs of persons at risk or with functional limitations resulting from disease, trauma, aging, and/or congenital and/or developmental conditions. Such a system of services may be achieved by accessing a single provider, multiple providers, and/or a network of providers. The intensity and diversity of services may vary depending on the functional and psychosocial needs of the persons served.

Contract: A written agreement between two or more parties that sets forth enforceable obligations between or among the parties.

Controlled/operated: The right or responsibility to exercise influence over the physical conditions of a facility where service delivery/administrative operations occur. An organization is considered in control of all facilities where it delivers services to persons who are present at the time of service delivery for the sole purpose of receiving services from the organization (e.g., services provided to students at a school outside of the school's regular school, pre-school, or after-school program hours). An organization is not considered in control of facilities where it delivers services to persons who are present at the time of service delivery for purposes other than receiving services from the organization (e.g., services provided at a school to students who are present at the school to participate in the school's regular school, pre-school, or after-school programs).

Co-pharmacy: (Behavioral Health, Child and Youth Services, and Opioid Treatment Program) The use of two or more medications from the same class, e.g., two antidepressant medications or two antipsychotic medications.

Core values: The essential and enduring tenets of an organization. They are a small set of timeless guiding principles that require no external justifications. They have intrinsic value and importance to those inside the organization.

Corporate citizenship: An organization's efforts, activities, and interest in integrating, contributing, and supporting the communities where it delivers services to better address the needs of persons served.

Corporate status: The existence of an entity as a corporation under applicable law. Maintenance of corporate status typically requires ongoing compliance with state requirements.

Costs: The expenses incurred to acquire, produce, accomplish, and maintain organizational goals. These include both direct costs, such as those for salaries and benefits, materials, and equipment, and indirect costs, such as those for electricity, water, building maintenance, and depreciation of equipment.

Cultural competency: An organization's ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs, and values that reflect an individual's racial, ethnic, religious, and/or social groups or sexual orientation.

Culturally normative: Providing the persons served with an opportunity to experience patterns and conditions of everyday life that match as closely as possible those patterns and conditions typical of the mainstream experience in the local society and community. This requires the use of service delivery systems and settings that adapt to the changing norms and patterns of communities in which the persons served function so as to incorporate the following features:

- Rhythms of the day, week, and year and life cycles that are “normal” or typical of the community.
- A range of choices, with personal preferences and self-determination receiving full respect and consideration.
- A variety of social interactions and settings, including family, work, and leisure settings and opportunities for personal intimacy.
- Normal economic standards.
- Life in housing typical of the local neighborhoods.

Culture: The integrated pattern of human behavior that includes the thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, social, or other group.

Customers: The persons served, families, communities, funding agencies, employers, etc.,
who receive or purchase services from the organization.

**Data:** A set of values of qualitative or quantitative variables, e.g., facts, objective information, or statistics collected, assembled, or compiled for reference, analysis and use in decision-making.

**Demonstrate:** To show, explain, or prove by evidence presented in program documentation, interviews, and behavior how an organization or a program consistently conforms to a given standard.

**Debt covenants:** Requirements found in loan documents that require an organization to meet certain predefined performance targets to be measured at predefined time periods. The performance targets can be financial (for example, the organization must maintain a certain level of days with cash on hand) or nonfinancial (an organization must maintain a certain occupancy level).

**Detoxification treatment:** (Opioid Treatment Program) Dispensing an opioid agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects of withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state within such period.

**Discharge summary:** (Aging Services, Behavioral Health, Child and Youth Services, and Opioid Treatment Program) A document prepared at discharge by the staff members designated with the responsibility for service coordination that summarizes the person’s course of treatment, level of goal(s) achievement, final assessment of current condition, and recommendations and/or arrangements for further treatment and/or aftercare.

**Diversion control plan:** (Opioid Treatment Program) A document that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use and must assign specific responsibility to medical and administrative staff for implementation.

**Diversity:** Differences due to cognitive or physical ability, culture, ethnicity, language, religion, economic status, gender, age, or sexual orientation.

**Donated location/space:** Physical space not owned or leased by the organization but made available to the organization without charge for the purposes of delivering services or for administrative operations on an ongoing basis and which the organization controls or operates during the time of service delivery/administrative operations. The location and availability of the space does not vary at the discretion of the donating entity.

**Durability:** Maintenance or improvement over time of outcomes achieved by persons served at the time of discharge.

**Duty of care:** Obligation of governing board members to act with the care that an ordinarily prudent person in a similar position would use under similar circumstances. This duty requires governing board members to perform their duties in good faith and in a manner they reasonably believe to be in the organization’s best interest.

**Duty of loyalty:** Obligation of governing board members to refrain from engaging in personal activities that would harm or take advantage of the organization. This duty prohibits governing board members from using their position of trust and confidence to further their private interests. It requires an undivided loyalty to the organization and demands that there be no conflict between a governing board member’s corporate duty and self-interest.

**Duty of obedience:** Obligation of governing board members to perform their duties according to applicable statutes and the provisions of the organization’s articles of incorporation and bylaws.

**Effectiveness:** Results achieved and outcomes observed for persons served. Can apply to different points in time (during, at the end of, or at points in time following services). Can apply to different domains (e.g., change in disability or impairment, function, participation in life’s activities, work, and many other domains relevant to the organization).
**Glossary**

**Efficacy:** The ability to produce an effect, or effectiveness.

**Efficiency:** Relationship between resources used and results or outcomes obtained. Resources can include, for example, time, money, or staff/FTEs. Can apply at the level of the person served, program, or groups of persons served or at the level of the organization as a whole.

**Employee-owner:** An individual who delivers administration or services on behalf of an organization if such individual is also:
- with respect to a for-profit organization, a person holding an ownership interest in the organization; or
- with respect to a nonprofit organization, a person with the right to vote for the election of the organization’s directors, unless that right derives solely from the person’s status as a delegate or director.

**Entitlements:** Governmental benefits available to persons served and/or their families.

**Executive leadership:** The organization’s principal management employee, often referred to as the chief executive officer, president, or executive director. The executive leadership is hired and evaluated directly by the organization’s governing board and is responsible for leading management in conducting the organization’s business and affairs.

**Family/support system:** (Aging Services, Continuing Care Retirement Communities, and Medical Rehabilitation) A group of persons of multiple ages bonded by affection, biology, choice, convenience, necessity, or law for the purpose of meeting the individual needs of its members.

**Family:** (Behavioral Health, Child and Youth Services, Employment and Community Services, Vision Rehabilitation Services) A person’s parents, spouse, children, siblings, extended family, guardians, legally authorized representatives, or significant others as identified by the person served.

**Family of origin:** Birth family or first adoptive parents.

**Fee schedule:** A listing of prices for services rendered. These prices may be designed for and used with third-party payers, outside funding sources, and/or the persons served, their families, and caregivers.

**Functional literacy:** The ability to read, comprehend, and assimilate the oral and written language and numerical information required to function in a specific work or community environment. Accommodation strategies for those with reduced functional literacy may include picture instructions and audio or video recordings.

**Governance authority:** (Medical Rehabilitation, Opioid Treatment Program) The individual or group that provides direction, guidance, and oversight and approves decisions specific to the organization and its services. This is the individual or group to which the chief executive reports.

**Governing board:** The body vested with legal authority by applicable law to direct the business and affairs of a corporate entity. Such bodies are often referred to as boards of directors, trustees, or governors. Advisory and community relations boards and management committees do not constitute governing boards.

**Governmental:** Regarding any city, county, state, federal, tribal, provincial, or similar jurisdiction.

**Grievance:** A perceived cause for complaint.

**Home:** (Employment and Community Services) The individual’s living environment as impacted by the individual’s personal articles, friends, roommates, or significant others. Individuals’ homes are considered central to their identity.

**Host organization:** Employer of an individual eligible for employee assistance program services.

**Impairment:** Problems in body function or structure such as a significant deviation or loss. (This definition is from the World Health Organization’s *International Classification of Functioning, Disability, and Health [ICF]*.)

**Implement:** Consistent actions that demonstrate a policy, plan, procedure, or practice is in effect.

**Independent (board representation):** The absence of conflict of interest by a governing
board member with respect to any organizational transaction. A governing board member is typically independent with respect to a transaction if neither the individual nor any related person or entity benefits from the transaction or is subject to the direction or control of a person or entity that benefits from the transaction. (See definition of unrelated.) For purposes of the foregoing, direction or control is often evidenced by the existence of an employment relationship or other compensation arrangement.

**Indigenous:** Indigenous people are the descendants—according to a common definition—of those who inhabited a country or a geographical region at the time when people of different cultures or ethnic origins arrived. CARF is using the term indigenous as a generic term as defined by the United Nations for many years. Practicing unique traditions, indigenous people retain social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live. In some countries, there may be preference for other terms including tribes, first peoples, or Aboriginals; specific examples include Native Americans, First Nations, Métis, and Inuit.

**Individual plan:** An organized written statement of the proposed service/treatment process to guide a provider and a person served throughout the duration of service/treatment. It identifies the input from the person served regarding goals and objectives and services to be provided, persons responsible for providing services, and input from the person served.

**Information:** Understanding derived from looking at facts; conclusions from looking at data.

**Informed choice:** A decision made by a person served that is based on sufficient experience and knowledge, including exposure, awareness, interactions, or instructional opportunities, to ensure that the choice is made with adequate awareness of the alternatives to and consequences of the options available.

**Integration:** (Behavioral Health, Child and Youth Services) Presence and participation in the mainstream of community life. Participation means that the persons served maintain social relationships with family members, peers, and others in the community who do not have disabilities. In addition, the persons served have equal access to and full participation in community resources and activities available to the general public.

**Integration:** (Aging Services, Continuing Care Retirement Communities, Employment and Community Services, Medical Rehabilitation, Vision Rehabilitation Services) The opportunity for involvement in all aspects of community life. Integration into communities, work settings, and schools provides all individuals opportunities to be active, fully participating members of those communities or environments. In integrated settings, diversity is viewed as a goal; it is recognized that diversity enriches all community members.

**Interdependence:** Movement from dependence toward interdependence may be demonstrated by an increase in self-sufficiency, self-advocacy, or self-determination, with offsetting decreases in artificial or paid services.

**Interdisciplinary:** Characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of a person’s program. There must be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals.

**Investigation:** A detailed inquiry or systematic examination by a third party into the appropriateness of acts by an organization or its personnel, if such acts: (a) relate directly to conformance or nonconformance to applicable standards; or (b) are of such breadth or scope that the organization’s entire operations may be affected. Without limiting the foregoing, an investigation includes any governmental notice of regulatory or other noncompliance that requires submission of a written corrective action plan.

**Joint venture:** A business undertaking by two or more legal entities in which profits, losses, and control are shared, which may or may not involve the formation of a new legal entity. If a new entity is formed, the original entities continue to exist.
**Kinship care:** (Child and Youth Services) Kinship care is the full-time care, nurturing and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child. This definition is designed to be inclusive and respectful of cultural values and ties of affection. It allows a child to grow to adulthood in a family environment. (This definition is from the Child Welfare League of America [CWLA].)

**Leadership:** Leadership creates and sustains a focus on the persons served, the organization's core values and mission, and the pursuit of organizational and programmatic performance excellence. It is responsible for the integration of the organization's core values and performance expectations into its management system. Leadership promotes and advocates for the organization's and community's commitment to the persons served.

**Linkages:** Established connections and networks with a variety of agencies, companies, and persons in the community.

**Living arrangements:** (Employment and Community Services) The individual model of services delivered—Supported Living, Independent Living, Group Home, Intermediate Care Facility (ICF), etc.

**Long-term detoxification treatment:** (Opioid Treatment Program) Detoxification treatment for more than 30 days but no more than 180 days.

**Maladaptive behavior:** Behavior that is destructive to oneself, others, or the environment, demonstrating a reduction or lack of the ability necessary to adjust to environmental demands.

**Manual skills:** The instructional area that is designed to assess and enhance skills in all aspects of sensory awareness with an emphasis on adaptive and safety techniques. Skill training focuses on organization, tactual awareness, spatial awareness, visual skills, memory sequencing, problem solving, and confidence building. Activities range from basic tasks using hand tools to advanced tasks using power tools and woodworking machinery.

**Material litigation:** A legal proceeding initiated by a third party concerning the appropriateness of acts by an organization or its personnel, if such acts: (a) relate directly to conformance or non-conformance to applicable standards; or (b) are of such breadth or scope that the organization's entire operations may be affected.

**Medical director:** (Opioid Treatment Program) A physician, licensed to practice medicine in the jurisdiction in which the opioid treatment program is located, who assumes responsibility for administering all medical services performed by the program either by performing them directly or delegating specific responsibility to authorized program physicians and healthcare professionals functioning under the medical director's direct supervision.

**Medically complex:** (Behavioral Health, Child and Youth Services) Persons who have a serious ongoing illness or a chronic condition that meets at least one of the following criteria:
- Has lasted or is anticipated to last at least twelve months.
- Has required at least one month of hospitalization.
- Requires daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members.
- Requires the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.
- The medically complex condition of the person served presents an ongoing threat to his or her health status.

**Medically fragile:** (Employment and Community Services) An individual who has a serious ongoing illness or a chronic physical condition that has lasted or is anticipated to last at least 12 months or who has required at least one month of hospitalization. Additionally, this individual may require daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members. Moreover, this individual...
may require the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.

**Medically supervised withdrawal (MSW):** A medically supervised, gradual reduction or tapering of dose over time to achieve the elimination of tolerance and physical dependence to methadone or other opioid agonists or partial agonists.

**Medication-assisted treatment: (Opioid Treatment Program)** Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance use disorders, a combination of medication and behavioral therapies is most successful. MAT is clinically driven with a focus on individualized patient care. (Definition from SAMHSA)

**Medication control: (Aging Services, Behavioral Health, Child and Youth Services, Employment and Community Services, Opioid Treatment Program)** The practice of providing a secure storage area and controlled access for medications that are brought into a program and used by the person served. This would include medications self-administered by the persons served or the use of samples.

**Medication management: (Aging Services, Behavioral Health, Child and Youth Services, Employment and Community Services, Opioid Treatment Program)** The practice of prescribing, administering, and/or dispensing medication by qualified personnel.

It is considered management when personnel in any way effect dosage, including taking pills out of a bottle or blister pack; measuring liquids; or giving injections, suppository, or PRN medications.

**Medication management: (Opioid Treatment Program)** The practice of prescribing, administering, and/or dispensing any medications approved for the treatment of opioid use disorder by qualified medical personnel.

**Medication monitoring: (Employment and Community Services, Vision Rehabilitation Services)** The practice of providing a secure storage area and controlled access for medications that are brought into a program and used by the person served. The person served must take the medication without any assistance from personnel.

**Medication unit: (Opioid Treatment Program)** A facility that is part of but geographically separate from an opioid treatment program from which licensed private practitioners or community pharmacists dispense or administer an opioid agonist treatment medication or collect samples for drug testing or analysis.

**Medication use: (Aging Services, Behavioral Health, Child and Youth Services, Employment and Community Services, Opioid Treatment Program)** The practice of handling, prescribing, dispensing and/or administering medication to persons served in response to specific symptoms, behaviors, and conditions for which the use of medications is indicated and deemed efficacious.

**Mental status:** A person's orientation, mood, affect, thought processes, developmental status, and organic brain function.

**Merger:** The combination of two or more legal entities into a single legal entity, where one entity continues in existence and the others cease to exist. In a merger, the surviving entity retains its name and identity and acquires the assets and liabilities of the disappearing entities.

**Mission:** An organization's reason for being. An effective mission statement reflects people's idealistic motivations for doing the organization's work.

**Natural proportions:** A principle that states that the number of persons served in any given setting, such as a work setting, should be in proportion to the number of persons with disabilities in the general population.

**Natural supports: (Behavioral Health, Child and Youth Services)** Supports provided that assist the persons served to achieve their goals of choice and facilitate their integration into the community. Natural supports are provided by persons who are not paid staff members of a service...
provider but may be initiated or planned, facilitated in partnership with such a provider.

**Natural supports:** (Employment and Community Services, Vision Rehabilitation Services)
Supports that occur naturally in the community, at work, or in a social situation that enable the persons served to accomplish their goals in life without the use of paid supports.

**Offender:** An inmate, detainee, or anyone under the community supervision of a criminal justice agency.

**On-the-job evaluation:** An evaluation performed in a work setting located outside the organization in which a person is given the opportunity to experience the requirements necessary to do a specific job. Real work pressures are exerted by the employer, and the person's performance is evaluated by the employer and the evaluator.

**Opioid agonist treatment medication:** (Opioid Treatment Program) Any opioid agonist drug approved by the U.S. Food and Drug Administration under Section 505 of the Federal Food, Drug, and Cosmetic Act for use in the treatment of opioid use disorder.

**Organization:** A legal entity that provides an environment within which services or programs are offered.

**Orientation and Mobility (O&M):** The instructional area that addresses the use of the remaining senses in combination with skill training utilizing protective techniques and assistive devices in order to travel independently in a safe, efficient, and confident manner in both familiar and unfamiliar environments.

**Outcome:** Result or end point of care or status achieved by a defined point following delivery of services.

**Outcomes measurement and outcomes management:** A systematic procedure for determining the effectiveness and efficiency of results achieved by the persons served during service delivery or following service completion and of the individuals' satisfaction with those results. An outcomes management system measures outcomes by obtaining, aggregating, and analyzing data regarding how well the persons served are functioning after transition/exit/discharge from a specific service. Outcomes measures should be related to the goals that recent services were designed to achieve. Other measures in the outcomes management system may include progress measures that are appropriate for long-term services (longer than six months in duration) that serve persons demonstrating a need for a slower pace in order to achieve gains or changes in functioning.

**Paid work:** Employment of a person served that results in the payment of wages for the production of products or provision of services. Paid work meets the state and/or federal definition of employment.

**Participation:** An individual's involvement in life situations. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health* [ICF].)

**Participation restrictions:** Problems an individual may experience in involvement in life situations. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health* [ICF].)

**Pathological aging:** Changes due to the impact of disease versus the normal aging process.

**Pediatric medicine:** The branch of medicine dealing with the growth, development, and care of infants, children, and adolescents and with the treatment of their diseases.

**Performance indicator:** A quantitative expression that can be used to evaluate key performance in relation to objectives. It is often expressed as a percent, rate, or ratio. For example, a performance indicator on return to work might be: percentage of clients in competitive employment 90 days after closure.

**Performance target:** Measurable level of achievement identified to show progress toward an overall objective. This could be set internally by the program, organization, or it could be a target established by an external entity. The performance target could be expressed as a certain percentage, ratio, or number to be reached.
Periodically: Occurring at intervals determined by the organization. The organization uses information about and input from the persons served and other stakeholders to determine the frequency of the intervals.

Person served: The primary consumer of services. When this person is unable to exercise self-representation at any point in the decision-making process, person served also refers to those willing and able to make decisions on behalf of the primary consumer. These individuals may include family members, legal representatives, guardians, and/or advocates, as appropriate. The organization should have a means by which a legal representative of the primary consumer, if any, is invited to participate at appropriate points in the decision-making process. By the same token, a person who is legally able to represent his/her own interests should be granted the right to choose whether other members of the family, significant others, or advocates may participate in that decision-making process.

Personal care: Services and supports, including bathing, hair care, skin care, shaving, nail care, and oral hygiene; alimentary procedures to assist one with eating and with bowel and bladder management; positioning; care of adaptive personal care devices; and feminine hygiene.

Personal representative: An individual who is designated by a person served or, if appropriate, by a parent or guardian to advocate for the needs, wants, and rights of the person served.

Personnel: Workers involved in the delivery, oversight, and support of the programs/services seeking accreditation, regardless of employment status.

Persons with severe and persistent mental illness: (Behavioral Health) Adults with a primary diagnosis of schizophrenia, psychiatric disorders, major affective disorders (such as treatment resistant major depression and bipolar disorder), or other major mental illness according to the current Diagnostic and Statistical Manual of Mental Disorders, which may also include a secondary diagnosis.

Pharmacotherapy: Any treatment of the persons served with prescription medications, including methadone or methadone-like drugs.

Plan: Written direction that is action oriented and related to a specific project or defined goal, either present and/or future oriented. A plan may include the steps to be taken to achieve stated goals, a timeline, priorities, the resources needed and/or available for achieving the plan, and the positions or persons responsible for implementing the identified steps.

Plan of care: The document that contains the program that has been designed to meet the needs of the person served. This document is prepared with input from the team, including the person served. The plan is modified and revised, as needed, depending upon the needs of the person served.

Policy: Written course of action or guidelines adopted by leadership and reflected in actual practice.

Polypharmacy: (Behavioral Health, Child and Youth Services, and Opioid Treatment Program) The use of multiple medications to treat different conditions.

Predicted outcomes: The outcomes established by the team at the time of the completion of the initial assessment.

Preferred practice patterns: Statements developed as a guideline for blind rehabilitation specialists that specify procedures, clinical indications for performing the procedures, clinical processes, setting, equipment specifications, documentation aspects, and expected outcomes.

Prevailing wage: A wage paid to experienced workers in the vicinity who do not have disabilities that impede them in doing the work to be performed. An experienced worker is one who has become proficient in performing a job and is not receiving entry-level wages. Prevailing wage rates must be based on work done using similar methods and equipment. The information to be recorded in documenting prevailing wage rates includes:

- The date of contact with the firm.
The name, address, and phone number of the firm.

The individual contacted within the firm.

The title of the individual contacted.

The wage range provided.

A brief description of the work for which information is provided.

The basis for the conclusion that the wage rate is not based on an entry-level position.

**Primary care:** Active, organized, structured treatment for a presenting illness.

**Private homes:** An apartment, duplex, house, or condominium owned or leased by a person served.

If a person served and the organization co-sign a lease for the person served for an apartment, duplex, or townhouse, this living arrangement will be considered a private home. The organization will not technically be considered a lessor of this private home for the person served, but will be considered a financial guarantor for the person served who is leasing his or her own private home.

**Procedure:** A “how to” description of actions to be taken. Not required to be written unless specified.

**Prognosis:** The process of projecting:

- The likelihood of a person achieving stated goals.
- The length of time necessary for the person to achieve his or her rehabilitation goals.
- The degree of independence the person is likely to achieve.
- The likelihood of the person maintaining outcomes achieved.

**Program:** A system of activities performed for the benefit of persons served.

**Program sponsor:** (Opioid Treatment Program) The person named in the application for certification as responsible for the opioid treatment program and who assumes responsibility for all its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program or any medication units.

**Proprietary organization:** An organization that is operated for profit.

**Publicly operated organization:** An organization that is operated by a governmental entity.

**Qualified behavioral health practitioner:** (Behavioral Health, Child and Youth Services, Opioid Treatment Program) A person certified, licensed, registered, or credentialed by a governmental entity or professional association as meeting the educational, experiential, or competency requirements necessary to provide mental health or alcohol and other drug services. Persons other than a physician who are designated by a program to order seclusion or restraints must be permitted to do so by federal, state, provincial, or other regulations.

**Qualified practitioner:** (Child and Youth Services) A person who is certified, licensed, registered, or credentialed by a governmental entity or professional association as meeting the educational, experiential, or competency requirements necessary to provide human services.

**Reasonable accommodations:** Modifications or adjustments, which are not unduly burdensome, that assist the persons served or staff members to access benefits and privileges that are equal to those enjoyed by others. Examples taken from the Americans with Disabilities Act include making existing facilities readily accessible to and usable by persons with disabilities; restructuring jobs; modifying work schedules; reassigning persons to vacant positions; acquiring or modifying equipment or assistive devices; adjusting or modifying examinations, training materials, policies, and procedures; and providing qualified readers or interpreters.

**Regular:** Occurring at fixed, uniform intervals of time determined by the organization. The organization assesses and uses information about and input from the persons served and other stakeholders to determine the frequency necessary.

**Rehabilitation:** The process of providing those comprehensive services deemed appropriate to the needs of persons with disabilities in a coordinated manner in a program or service...
designed to achieve objectives of improved health, welfare, and realization of the person’s maximum physical, social, psychological, and vocational potential for useful and productive activity. Rehabilitation services are necessary when a person with a disability is in need of assistance and it is beyond the person’s personal capacities and resources to achieve his or her maximum potential for personal, social, and economic adjustment and beyond the capabilities of the services available in the person’s usual daily experience. Such assistance continues as long as the person makes significant and observable improvement.

Rehabilitation nursing services: The formalized organizational structure that delineates the appropriate accountability, staff mix, and competencies and provides a process for establishing, implementing, and maintaining patient care standards and nursing policies that are specific to rehabilitation nursing. The nursing staff includes members who provide direct care and those who provide supervision and perform support functions. This staff usually includes clinical nurse specialists, registered nurses, licensed practical (vocational) nurses, nursing assistants, and unit clerical support. Nursing services are provided under the direct supervision of a registered nurse unless supervision is otherwise defined by applicable state practice acts or provincial legislation for nursing.

Rehabilitative treatment environment: A rehabilitation setting that provides for:
- The provision of a range of choices, with personal preference and self-determination receiving full respect and consideration.
- A variety of social interactions that promote community integration.
- Treatment of a sufficient volume of persons served to ensure that there is an environment of peer support and mentorship.
- Treatment of a sufficient volume of persons served to support professional team involvement and competence.
- A physical environment conducive to enhancing the functional abilities of the persons served.

Reliability: The process of obtaining data in a consistent or reproducible manner.

Representative sample/sampling: A group of randomly selected individuals determined through a procedure such that each person has an equal probability of inclusion in the sample. If sampling is used, the sample should reflect the population to which the results are generalized. Although no specific percentage of persons served is required to be included in the sample, general principles of data analysis state that the larger the sample, the less the error that is expected in comparing the sample to the entire population of persons served. The number of persons sampled within each program area or subgroup should be sufficient to give confidence that the characteristics of the sample reflect the distribution of the entire population of persons served.

Residence: (Employment and Community Services) The actual building or structure in which a person lives.

Residential settings: (Employment and Community Services) The individual model of services delivered—Supported Living, Independent Living, Group Home, Intermediate Care Facility (ICF), etc.

Restraint: The use of physical, mechanical, or other means to temporarily subdue an individual or otherwise limit a person’s freedom of movement. Restraint is used only when other less restrictive measures have been found to be ineffective to protect the person served or others from injury or serious harm.

Risk: Exposure to the chance of injury or loss. The risk can be external, such as a natural disaster, injury that occurs on the property of a program, or fire. The risk can be internal to the organization and include things such as back injuries while performing job duties, it can involve liability issues such as the sharing of information about a person served without consent, or it can jeopardize the health of those internal or external to the organization due to such things as poor or nonexistent infection control practices.

Risk factors: (Behavioral Health) Certain conditions and situations that precede and may predict
the later development of behavioral health problems. Examples of risk factors may include poverty, family instability, or poor academic performance. Examples of protective factors may include an internal locus of control, a positive adult role model, and a positive outlook.

**Risk factors:** Aspect of personal behavior or lifestyle, environmental exposure, or variable or condition that increases the likelihood of an adverse outcome.

**Screening:** A face-to-face, computer-assisted, or telephone interview with a person served to determine his or her eligibility for services and/or proper referral for services.

**Seclusion:** The separation of an individual from normal program participation in an involuntary manner. The person served is in seclusion if freedom to leave the segregated room or area is denied. Voluntary time-out is not considered seclusion.

**Sentinel event:** An unexpected occurrence within a CARF-accredited program involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such an event is called sentinel because it signals the need for immediate investigation and response. Without limiting the foregoing, a sentinel event includes any governmental notice of regulatory or other noncompliance that results in immediate jeopardy to the health or safety of any person (e.g., a Level 4 deficiency issued by the U.S. Centers for Medicare & Medicaid Services).

**Service:** Activities performed for the benefit of persons served.

**Service access:** The organization’s capacity to provide services to those who desire or are in need of receiving it.

**Service referral:** The practice of arranging for a person to receive the services provided by a given professional service unit of the organization or through some other appropriate agent. This arrangement, which is usually made by the individual responsible for the program of the person served, should be documented by notation in the person’s permanent record.

**Short-term detoxification treatment:** (Opioid Treatment Program) Detoxification treatment for no more than 30 days.

**Should:** Inasmuch as CARF is a standards-setting and consultative resource rather than a regulatory or enforcement agency, the term should is used synonymously with the term shall. CARF’s intent is that each applicable standard and each policy within this document will be addressed and met by organizations seeking to become accredited or maintain current accreditation.

**Skilled healthcare provider:** Licensed, certified, or registered healthcare provider (e.g., nurse, physician, or respiratory therapist).

**Skilled healthcare provider:** (Behavioral Health, Child and Youth Services) Licensed, certified, or registered healthcare provider (e.g., nurse, physician, or respiratory therapist). Can also include specifically trained natural or foster family member knowledgeable in the care of the specific individual.

**Staff member:** A person who is directly employed by an organization on either a full- or part-time basis.

**Stakeholders:** Individuals or groups who have an interest in the activities and outcomes of an organization and its programs and services. They include, but are not limited to, the persons served, families, governance or designated authority, purchasers, regulators, referral sources, personnel, employers, advocacy groups, contributors, supporters, landlords, business interests, and the community.

**Strategic planning:** An organization’s directional framework, developed and integrated from a variety of sources, including but not limited to financial planning, environmental scans, and organizational competencies and opportunities.

**Supervisor:** The lead person who is responsible for an employee’s job performance. A supervisor may be a manager or a person with another title.
Supports: Individuals significant to a person served and/or activities, materials, equipment, or other services designed and implemented to assist the person served. Examples include instruction, training, assistive technology, and/or removal of architectural barriers.

Team: At a minimum, the person served and the primary personnel directly involved in the participatory process of defining, refining, and meeting the person’s goals. The team may also include other significant persons such as employers, family members, and/or peers at the option of the person served and the organization.

Team integration: The process of bringing individuals together or incorporating them into a collaborative team. The entire team becomes the dominant culture and decision-making body for the rehabilitation process. There is recognition of and respect for the value of information provided by an individual team member, with a focus on the interdependence and coordination of all team members. Through coordinated communication, there is accountability by the team 24 hours per day, 7 days per week for all decisions made.

Transition (from school): (Employment and Community Services) The process of moving from education services to adult services, including living and working in the community.

Transition: The process of moving from one level of care or service/support to another, changing from child/adolescent service systems to adult systems, or leaving care or services/supports.

Transition plan: (Aging Services, Behavioral Health, Child and Youth Services, Opioid Treatment Program) A document developed with the full participation of the person served that (a) focuses on a successful transfer/transition between program or service phases/levels/steps or (b) focuses on a successful transition to a community living situation. The plan could be part of the individual plan and details how the person served will maintain the gains made during services and support ongoing recovery and/or continued well-being at the next phase/level/step.

Treatment: A professionally recognized approach that applies accepted theories, principles, and techniques designed to achieve recovery and rehabilitative outcomes for the persons served.

Unrelated (board representation): The absence of an affiliation between a governing board member and any person or entity that benefits from any organizational transaction. For purposes of the foregoing, affiliation generally means a relationship that is:

- Familial;
- Characterized by control of at least a 35 percent voting, profits, or beneficial interest by the member; or
- Substantially influenced by the member.

Validity: Refers to the appropriateness, meaningfulness, and usefulness of a measure and the inferences made from it. Commonly regarded as the extent to which a test measures what it is intended to measure.

Value: The relationship between quality and cost.

Visit: Episode of service delivery to one person served on one day by one service or discipline.

Visual skills: The instructional area that addresses the needs of persons with partial vision to gain a better understanding of their eye problems through patient education and teaches them how to utilize their remaining vision effectively through the use of low vision techniques. It also includes assessment and training with special optical aids and devices designed to meet the various needs of the persons served. These needs may include reading, activities of daily living, orientation, mobility, and home repairs.

Wellness education: Learning activities that are intended to improve the patient’s health status. These include but are not limited to healthcare education, self-management of medication(s), nutritional instruction, exercise programs, and training in the proper use of exercise equipment.

Youth: The time a person is young—generally referring to the time between childhood and adulthood.
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