*Instructions: Within this document, italicized font is instructions, directions, and/or suggestions, while* regular font *is recommended text you may use within your document. Red text indicates information specific to a particular facility type. Use of this template format is optional. It is not required and is intended only to assist in the development process of an ICF/DD-H or ICF/DD-N Program Plan. (remove this and all other italicized text prior to submitting program plan)*

**Cover/Title Page Here**

**Table of Contents Here**

**I. INTRODUCTION**

### PHILOSOPHY/GOALS

*Describe your program and/or agency philosophy and goals here.*

### CLIENT PROFILE/ADMISSION CRITERIA

*A profile of the client population using the CDER - provide a narrative regarding the client population to be served at your facility. Include a summary of the clients’ nursing and developmental priority needs. The profile should be generalized and not specific to any one individual.*

*Admission criteria to include:*

A. The facility may accept clients with developmental disabilities who meet the following criteria:

1. Number of Clients:
2. Age Range:
3. Gender:
4. Ambulatory Status:
5. Range of Disability:
6. Two or more developmental deficits as measured by the Client Development Evaluation Report (CDER):

*ICF/DD-H:* in any one of the two domains: (a) self-help; (b) social-emotional.

*ICF/DD-N:* in any combination of the three domains: a) self-help; b) motor; c) social/emotional.

1. Level of Ability: Eating, Toileting, Hygiene, etc
2. Hearing/Vision Considerations:
3. Behaviors:
4. Has a need for specialized developmental, training, and habilitative program services:
5. *ICF/DD-N*: Requires 24-hour nursing supervision and intermittent skilled nursing services such as:

Apnea monitoring

Gastrostomy feeding and care

*Other* (*add which nursing service needs your facility will accept)*

1. *Other*: *(include any other admission criteria here)*

B. The facility may not accept clients who:

1. Have had violent episodes which have caused physical injury within the past year.
2. Cause severe self-injury which requires physician's treatment at least once per year.
3. Smear feces at every opportunity.
4. *ICF/DD-H:* Have a decubitus ulcer/pressure sore at any stage. *ICF/DD-N:* Have a decubitus ulcer/pressure sore at the third or fourth stage of development.
5. Have clinical evidence of an active communicable disease.
6. *Other (add other criteria here)*

### DISCHARGE CRITERIA

*Include information on discharge from the facility here, including reasons for discharge and the discharge process.*

### II. CLIENT ASSESSMENT

### PRE-ADMISSION EVALUATION

*In this section, include who is responsible for completion of the pre-admission evaluation, what information is gathered/reviewed, and the time frame for completion, etc.*

### 30 DAY POST ADMISSIONS

*The facility must conduct an initial assessment of each client to identify the current level of needs and function utilizing standard assessment forms. Explain the facility process in this section. Refer to state and federal requirements.*

*Include the following information:*

The QIDP, interdisciplinary professional staff/team members (IDPST), Regional Center representative, and (*add others*) shall review and update the preadmission evaluation within 30 days following client’s admission.

The Interdisciplinary Team (IDT) shall develop a comprehensive written assessment, which shall provide the basis for formulating an individual service plan which shall include, but not be limited to:

*(Note – The IDT includes the IDPST, QIDP, Regional Center, consumer, and other involved individuals, specific to the consumer.)*

* Nursing assessment
* Assessment of developmental status including strengths, weaknesses and needs.
* Prioritized objectives
* Discharge plan.

The IDT shall assess the client’s recreational interests.

The IDT shall consider the client’s need for guardianship or conservatorship if the client will attain majority or become emancipated prior to the next scheduled review.

The IDT shall provide for the protection of the client’s civil and legal rights.

The QIDP shall make available and interpret the assessment to the direct care staff, the client and when lawful, the client’s parents or authorized representative.

The Comprehensive Functional Assessment of each client must be reviewed by the IDT for relevancy and updated as needed.

### THE INTERDISCIPLINARY TEAM

The IDT consists of the following members:

Administrator

QIDP

Registered Nurse

*Other (list other potential IDT members)*

*Other*

*Other*

*Include general responsibilities of IDT members.*

### INDIVIDUAL SERVICE PLAN (ISP)

An Individual Service Plan (ISP) developed by the IDT under the direction of the QIDP is completed for each client, and reviewed semi-annually.

*Include the following information:*

Within 30 days after admission, the IDT must prepare for each client an ISP that states the specific objectives necessary to meet the client’s needs, as identified by the comprehensive assessment and planned sequence for dealing with those objectives. These objectives must:

1. Be stated separately in terms of a single behavioral outcome.
2. Be assigned projected completion dates.
3. Be expressed in behavioral terms that provide measurable indices of performance.
4. Be organized to reflect a developmental progression appropriate to the client.
5. Be prioritized.

*Include more information on ISP. What does it do/contain? Refer to state and federal regulations.*

### ISP IMPLEMENTATION

*Include information on how the ISP is implemented, how is it updated, and progress reviews here. Refer to state and federal regulations.*

**III. PROGRAM ELEMENTS**

**GENERAL DESCRIPTION**

*Include a general description of your program services here.*

*Include:*

The facility shall have the capability to provide program services to those clients it serves. These program services shall be based on the client’s specific needs as identified through the individual client assessment and include as appropriate:

*ICF/DD-H:*

* Sensory motor development
* Self-help skills training
* Behavior management program
* Habilitation program

*ICF/DD-N:*

* Nursing care activities.
* Habilitation programs, including but not limited to: Sensory motor development and Self-help skills training
* Behavior management program.

*Include the following sections as appropriate to your program:*

### NURSING CARE ACTIVITIES

*Address services provided.*

### HABILITATION

*Address services provided.*

### COMMUNICATION TRAINING

*Address services provided.*

### SENSORY MOTOR DEVELOPMENT

*Address services provided.*

### SELF HELP SKILLS TRAINING

*Address services provided.*

### SOCIAL / RECREATIONAL TRAINING

*Address services provided.*

### BEHAVIOR MANAGEMENT PROGRAM

*Address services provided. Be very general, as you will provide more detail about your program in Section IV.*

### *OTHER (identify other service(s) here)*

*Address any other services here.*

### ACTIVE TREATMENT

*Include this information:*

The facility shall provide no less than 56 hours of active treatment per week, including weekends/seven days per week. *For ICF/DD-N include this sentence:* For those clients who require a combination of developmental program services and nursing care activities, no less than 28 hours per week shall be devoted to the developmental programs unless otherwise approved in the facility program plan.

The active treatment program shall include: Any active treatment provided by agencies either outside or inside the facility shall be specified in the ISP, and a weekend program schedule which emphasizes recreational and social experiences as specified in the ISP. There will be no more than two consecutive hours not devoted to active treatment as specified in the ISP. If additional unstructured time is required, such need shall be determined by the IDT and documented in the client’s ISP and the facility’s program plan.

Each client must receive continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status.

### WEEKEND PROGRAMMING

*Discuss weekend programming which emphasizes social and recreational experiences here.*

### MONEY MANAGEMENT

The facility shall allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.

*The need for a formal money management program must be addressed in every client’s ISP by the IDT on an annual basis. The IDT must not conclude that a money management program is inappropriate based solely upon the level of intellectual or physical disability of the client. Include additional information here.*

**IV. BEHAVIOR MANAGEMENT PROGRAM**

### BEHAVIOR MANAGEMENT PROGRAM

*Include your Behavior Management Program here. Address all items from the checklist. Refer to the Code of Federal Regulations, the California Code of Regulations, Title 22, Title 17, and DDS’s web page for guidance.*

*Address:*

* *Facility philosophy*
* *Written: assessment, behavioral management plan, document which justifies use of interventions, and monthly reports*
* *Focus on positive behavioral supports*
* *Mild Restrictive Interventions to be used/not used*
* *Restrictive/Aversive techniques to be used/not used*
* *Psychotherapeutic drugs*
* *Emergency Behavioral Procedures*

### HUMAN RIGHTS COMMITTEE

*Include:*

The facility shall have a Human Rights Committee (HRC) with the responsibility for assuring that clients rights as specified in the W& I Code, Sections 4502-4505 and sections 50500-50550, Title 17 CAC are safeguarded. The committee is composed of the Administrator, QIDP, Registered Nurse, representative of the Regional Center (Service Coordinator/Case Manager), and with consent of the client, a client representative, parent or community representative, and may include a member of the State Council Regional Advisory Committee.

Minutes of every committee meeting shall be maintained in the facility and shall indicate the names of the members present, date, subject matter discussed and actions taken. The HRC shall meet at least quarterly.

The function of the HRC shall include:

* Development of policies and procedures to assure and safeguard the client's rights listed in W& I Code, Sections 4502-4505 and sections 50500-50550, Title 17 CAC.
* Monitor staff performance to ensure that policies and procedures are implemented.
* Document and participate in developing and implementing relevant in-service training programs.
* Review treatment modalities used by the facility where client human rights or dignity are affected.
* Review and approve at least annually, all behavior management programs. For those programs utilizing restrictive procedures, the minutes of the HRC shall reflect an examination of all previous treatment modalities used by the facility and shall document that the current program represents the least restrictive treatment alternative.
* Inform each client, parent (if the client is a minor) or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.
* (*Include other responsibilities if desired here*.)

**V. ORIENTATION AND IN-SERVICE TRAINING PROGRAM**

### INITIAL ORIENTATION TRAINING

*For ICF/DD-H include:*

All new staff, prior to providing direct client care, shall be provided eight (8) hours of orientation by a (*insert who will provide here*). These hours shall be documented and be completed during the first forty (40) hours of employment.

* A tour of the facility
* A description of the client population
* Special needs of clients with developmental disabilities
* Overall concepts of the facility’s program which meet the needs of the clients, including normalization
* Developmental growth and assessment
* Implementation of the ISP
* The clients’ activities of daily living
* Use of adaptive equipment or devices
* Unusual occurrences with clients, including but not limited to emergency procedures for relief of choking
* Fire and disaster plans

*For ICF/DD-N include:*

All new staff shall be provided sixteen (16) hours of orientation by a QIDP, Registered Nurse, Licensed Vocational Nurse or Licensed Psychiatric Technician. These hours shall be completed and be documented during the first forty (40) hours of employment.

***First Eight hours – Prior to providing direct care***

* A tour of the facility
* A description of the client population
* Clients daily schedule
* Instruction in the use and application of equipment and assistive devices
* Instruction in unusual occurrences and lifesaving procedures including but not limited to, emergency procedures for relief of choking
* Orientation to fire and disaster plans
* An introduction to client care and special needs of persons with developmental disabilities

***Second Eight hours***

* Administrative structure of the facility: Organization of staff, services offered, the role of direct-care staff, including job descriptions, the team concept and approaches to clients, and personnel policies
* The facility’s philosophy of client care
* Overall concepts of the facility’s program to meet the needs of the clients, including normalization and interdisciplinary professional staff team concept
* Developmental growth and assessment
* Client’s activities of daily living
* Implementation of the ISP
* Client’s rights
* Nursing policies and procedures
* Legal and ethical considerations of healthcare
* The role of federal and state regulations in the provision of care by employees

*For both types of facilities include:*

### IN-SERVICE TRAINING

*Include the following information:*

The facility shall require that all direct care staff receive at least 3 hours per month, 36 hours annually, of planned in-service education which shall be documented and shall include:

* Program techniques specific to the facility’s clients
* Developing program objectives for clients
* Evaluation, assessment techniques
* Documentation of client's response to his/her program including observation, reporting and recording
* Developmental special needs of clients
* Interpersonal relationships and communication skills between staff and clients
* Confidentiality of client information
* Detection of signs of illness or dysfunction that warrant medical or nursing interventions
* Basic nursing and health related skills
* Behavior management
* Emergency intervention procedures for behavior control
* Prevention and control of infection
* Fire and accident prevention and safety
* Clients rights as specified in Sections 4502 through 4501 of the W&I code and Sections 50500 through 50550 of Title 17, California Code of Regulations.
* Role and involvement of the parent, guardian, conservator or authorized representative in the client’s overall service plan
* Instruction in First Aid and CPR
* Instruction in the causes and treatment of epilepsy; care during and following an epileptic seizure; safety precautions; and protective equipment.
* Locating and using program reference materials
* Use and proper application of postural supports/supportive devices

*In addition, for ICF/DD-N include these topics:*

* Sensory deprivation and stimulation
* Psychosocial aspects of developmental disabilities as related to individual, family and community
* Maintenance of healthy skin; prevention of skin breakdown, body positioning and range of motion
* Oral hygiene
* Nutritional needs of clients including special feeding techniques
* Bladder and bowel training and management
* Disaster preparedness
* Caring for the dying client and understanding the grieving process

Documentation of in-service training shall be maintained, including the name and title of the presenter, date of presentation, title of subject covered including description and content, duration of the session, and the legible signature of those in attendance.

*Include additional information, such as your facility’s policy on staff attendance at trainings, make-up sessions, etc here. You may include an annual schedule of trainings.*

**VI.**

**ATTACHMENTS**

**ATTACHMENT # 1**

**ONE WEEK PROGRAM SCHEDULE FOR CLIENTS IN THE FACILITY**

### ONE WEEK PROGRAM SCHEDULE

*Either use a completed version of the example below or include a weekly calendar.*

***Program Activity Schedule: Monday - Friday***

6:00 – 7:00 am Wake up time followed by grooming training (washing face and hands, shaving, use of deodorant, toilet training and dressing training).

7:00 – 8:00 am Breakfast, eating skills, dishes

*ETC*

8:30 – 9:00 pm Preparation for bed.

9:00pm - Quiet time.

***Program Activity Schedule: Saturday - Sunday***

7:00 – 7:30 am Wake up time followed by grooming training (washing face and hands, shaving, use of deodorant); toilet and dressing training as well as bathing training for those who need it.

7:30 – 8:30 am Breakfast, eating skills, dishes

*ETC*

9:00 – 10:00 pm Preparation for bed.

10:00pm - Quiet time

**ATTACHMENT # 2**

**WEEKEND PROGRAMMING WHICH EMPHASIZES RECREATIONAL & SOCIAL EXPERIENCES**

### WEEKEND PROGRAMMING

*Include narrative or weekend calendar which demonstrates an emphasis on recreational and social experiences here.*

ATTACHMENT # 3

**FACILITY’S ORGANIZATIONAL CHART**

##### ORGANIZATIONAL CHART

***Sample:***

**ATTACHMENT # 4**

**THE IPST UTILIZED INDICATING THEIR DISCIPLINES WORKED EACH WEEK**

### CONSULTANTS/PROFESSIONAL STAFF

*Use Attachment #4 located on DDS’s web page or create your own chart. Example:*

|  |  |
| --- | --- |
| NAME/HOURS | CONSULTANTS/  PROFESSIONAL STAFF |
|  | QIDP |
|  | Administrator |
|  | Dentist |
|  | Dietitian |
|  | Physician |
|  | Registered Nurse |
|  | Pharmacist |
|  | Physical Therapist |
|  | Occupational Therapist |
|  | Psychologist |
|  | Recreational Therapist |
|  | Speech Pathologist |
|  | Audiologist |

**ATTACHMENT # 5**

**FACILITY PROGRAM STAFFING PATTERN**

*Sample Staffing Schedule (Sample schedules are also located on DDS’s webpage):*

**Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Capacity: \_\_\_\_\_ beds**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Hours** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| **1:00 am** |  |  |  |  |  |  |  |
| **2:00 am** |  |  |  |  |  |  |  |
| **3:00 am** |  |  |  |  |  |  |  |
| **4:00 am** |  |  |  |  |  |  |  |
| **5:00 am** |  |  |  |  |  |  |  |
| **6:00 am** |  |  |  |  |  |  |  |
| **7:00 am** |  |  |  |  |  |  |  |
| **8:00 am** |  |  |  |  |  |  |  |
| **9:00 am** |  |  |  |  |  |  |  |
| **10:00 am** |  |  |  |  |  |  |  |
| **11:00 am** |  |  |  |  |  |  |  |
| **12:00 pm** |  |  |  |  |  |  |  |
| **1:00 pm** |  |  |  |  |  |  |  |
| **2:00 pm** |  |  |  |  |  |  |  |
| **3:00 pm** |  |  |  |  |  |  |  |
| **4:00 pm** |  |  |  |  |  |  |  |
| **5:00 pm** |  |  |  |  |  |  |  |
| **6:00 pm** |  |  |  |  |  |  |  |
| **7:00 pm** |  |  |  |  |  |  |  |
| **8:00 pm** |  |  |  |  |  |  |  |
| **9:00 pm** |  |  |  |  |  |  |  |
| **10:00 pm** |  |  |  |  |  |  |  |
| **11:00 pm** |  |  |  |  |  |  |  |
| **12:00 am** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Total Staff Hours** |  |  |  |  |  |  |  |

**Total Hours For Week:**

|  |  |  |
| --- | --- | --- |
| **Staff Number** | **Staff Name** | **Type of Staff Lead/Direct Care** |
| **1** | **To Be Hired** | **Supervisor/Facility Manager** |
| **2** | **To Be Hired** | **Direct Training Staff** |
| **3** | **To Be Hired** | **Direct Training Staff** |
| **4** | **To Be Hired** | **Direct Training Staff** |
| **5** | **To Be Hired** | **Direct Training Staff** |
| **6** | **To Be Hired** | **Direct Training Staff** |
| **7** | **To Be Hired** | **Direct Training Staff/NOC** |
| **8** | **To Be Hired** | **Direct Training Staff/NOC** |

*Indicate which hours daily are designated as supervisory staff, 8 hours/day*

*Total minimum staffing hours: ICF/DD-H - 252 hours, ICF/DD-N - 280 hours for up to 6 bed facility*

**ATTACHMENT # 6**

**DESCRIPTION OF THE SPACE PROVIDED FOR PROGRAM ELEMENTS - FLOOR PLAN**

### DESCRIPTION OF PROGRAM SPACE

*Attach the facility Floor Plan, which indicates room sizes here.*

*Include a narrative description of the facility and grounds.*

**ATTACHMENT # 7**

**DESCRIPTION OF THE EQUIPMENT AVAILABLE OR TO BE OBTAINED FOR PROGRAM USE**

### PROGRAM EQUIPMENT

*Include a listing/description of typical programming equipment to be utilized at the facility here.*

**ATTACHMENT # 8**

**A PLAN FOR UTILIZATION OF COMMUNITY RESOURCES**

### PLAN FOR UTILIZATION OF COMMUNITY RESOURCES

*Include general narrative here.*

*Suggestions:*

MEDICAL NEEDS – MEDICAL HOSPITALS AND CLINICS

*Include information specific to your facility location here.*

SHOPPING

*Include information specific to your facility location here.*

RECREATION

*Include information specific to your facility location here.*

SPECIALIZED TRAINING / OTHER COMMUNITY RESOURCES

*Include information specific to your facility location here.*

**ATTACHMENT # 9**

**TASK TWO PROTOCOL: SYSTEMS DEVELOPED TO PREVENT, REPORT, AND INVESTIGATE REPORTED/SUSPECTED ABUSE**

### SYSTEMS DEVELOPED TO PREVENT, REPORT AND INVESTIGATE REPORTED/SUSPECTED ABUSE

*Include a narrative of your policy on client abuse and neglect, prevention, investigation of complaints, and reporting requirements. Refer to the Code of Federal Regulations, the California Code of Regulations, Title 22 and Title 17, and DDS’s web page for guidance.*

*Be sure to include any updated regulations and requirements, such as:*

*Two-hour reporting timeline for suspected abuse which results in serious bodily injury, including report to law enforcement, per Section 15630 of the Welfare and Institutions Code*

*Reporting requirements of Section 4659.2 of the Welfare and Institutions Code, which include the requirement to report death or serious injury related to the use of restraints, unexpected or suspicious death, allegation of sexual assault, or physical abuse reported to law enforcement to the “designated agency”, which is Disability Rights California.*

**ATTACHMENT # 10**

**QUALITY ASSURANCE PLAN**

### QUALITY ASSURANCE PLAN

*Include a narrative of your quality assurance plan here. Address items such as programming, operations, records review, and physical plant.*

*Optional – attach evaluation tools you will utilize.*

**ATTACHMENT # 11**

**Professional Staff**

### Professional Staff

*Attach copies of resumes, current licenses and/or degrees, and contracts of the consultant staff you will be utilizing at the facility here.*

**ATTACHMENT # 12**

**Transfer Agreement**

### Transfer Agreement

*Attach copy of Transfer Agreement with an acute hospital here.*

**ATTACHMENT # 13**

**Medication Training Program**

### Medication Training Program

*Attach your Medication Administration Training Program and corresponding checklist here. Refer to the checklist, regulations, and information on DDS’s web page for guidance.*

***(For ICF/DD-H:)***

**ATTACHMENT # 14**

**16 Hour New Provider Orientation**

### 16 Hour New Provider Orientation

*Attach evidence of attendance at the 16 Hour New Provider Orientation here.*

***(For ICF/DD-N:)***

**ATTACHMENT # 14**

**Attendant Training Program**

### Attendant Training Program

***ICF/DD-N only.***

*Attach form DS1853 and Attendant Training Program (include a minimum of one lesson plan from each of the four Modules) here.*

*Include a narrative overview of your Attendant Training Program.*

***(For ICF/DD-N:)***

**ATTACHMENT # 14.1**

**Specialized Procedures**

### Specialized Procedures

***ICF/DD-N only.***

*Specialized Procedures are facility and consumer specific. Complete only if there is a specific individual need. (For facilities already in operation or change of ownership.)*

*If needed, attach form DS 1851 and Specialized Procedures here.*

***(For ICF/DD-N:)***

**ATTACHMENT # 15**

**16 Hour New Provider Orientation**

### 16 Hour New Provider Orientation

*Attach evidence of attendance at the 16 Hour New Provider Orientation here.*

***(For ICF/DD-H:)***

**ATTACHMENT # 15**

**Emergency Preparedness Program**

### Emergency Preparedness Program

*Attach your Emergency Preparedness Program here. Refer to Federal Regulation §483.475 for guidance.*

***(For ICF/DD-N:)***

**ATTACHMENT # 16**

**Emergency Preparedness Program**

### Emergency Preparedness Program

*Attach your Emergency Preparedness Program here. Refer to Federal Regulation §483.475 for guidance.*