The Arc
Allegany-Steuben
New York

Quality Improvement Plan

Approved by the Board of Directors: March 25, 2026

Mission

To support and respect people's choices on their journey to independence.

Vision

A community of people who see opportunities in each other.

Values (I HEART)

Honor – Honesty about internal struggles/communication; around the future each person can expect; in the ways that you respect the transparency you would want for yourself.

Educate – Be a beacon of inspiration for people; of inclusion for communities; of advancement by talking, promoting and educating those who further the stigma; and of radiant positivity, always.

Adapt – Be open to change within the organization, to inspire opportunities within people; and to an ever-changing industry that requires patience and compassion.

Remain – Be committed to your community, your team and your people; to always doing what is right; and to making a positive impact every day.

Try – Be willing to be flexible with your team and on behalf of the people you support; to do everything you can to make a difference for one person; and to speak up as an agent of change when it is most needed.

The Arc Allegany-Steuben and its leadership have been committed to providing individualized and person-centered support to people with intellectual and developmental disabilities for over 60 years. With 24 locations in the two-county catchment area, we offer residential, site-based support, community support, employment services, self-directed options, and a variety of other supports. We intend that each interaction of our approximately 900 associates (as of 12/31/2025) is focused on supporting each person as an individual and for each person and their family to be highly satisfied in receiving competent and caring treatment. The person receiving support, their family, the organization, and the Board of Directors share in the commitment to continuously seek to improve services and the management of the organization.

As part of the improvement process, Arc Allegany-Steuben will focus on key quality indicators that require continuous focus and attention.

A. <u>OPWDD / OFPC REVIEWS/SURVEYS (Statements of Deficiency):</u>

Office for People with Developmental Disabilities (OPWDD) Bureau of Program Certification (BPC) completes reviews at all agencies including site, person centered, and agency reviews in areas such as fire safety, medication administration, health services, nutrition, physical plant, personal allowance, habilitation, etc. For some IRA's, BPC works with the Office for Fire Prevention and Control (OFPC) for fire safety. Any areas identified as problematic will result in a verbal recommendation, a finding on an Exit Conference form, a Statement of Deficiency (SOD), or a 45-day letter. Statements of Deficiency and 45-day letters require a Plan of Corrective Action (POCA) to OPWDD.

The Agency Protocol review occurs every 3 years. The Arc Allegany-Steuben Agency Review occurred on 9/5/2024. This review did not result in any statements of deficiency but there were several exit conference findings and recommendations that the agency addressed.

The Quality Department coordinates all OPWDD activities and responses including:

- Ensuring that the survey teams have access to the information and access to the sites that they need and assists the survey team during their reviews, as needed.
- For surveys that result in SOD's, the Quality Department and the program leadership work together to develop a comprehensive POCA including addressing the specific matter and incorporating a systemic/monitoring plan.
- For surveys that result in exit conference findings and/or recommendations/mentions, corrective actions are still expected from the program.
- Should a 45-day letter be issued to the agency, the Quality Director will ensure to communicate with The Arc NY.
- Share all survey data with the Board and the Quality Improvement Committee.
- Will complete data requirements of survey results with The Arc NY on a quarterly basis.

Please see below for the number of surveys, Statements of Deficiency, etc., for the past 2 years:

	2024	2025
Total Number of Surveys	40	44
Surveys resulting in SOD's (a site may have received more than one deficiency)	4	5
Annual percentage of surveys that resulted in a Statement of Deficiency	10%	11.4%

In 2025, the agency received Statements of Deficiency in the following areas:

- 2a-11: The site ensures that in home routine support/care necessary for people's health needs is provided in accordance with their service plans (program didn't follow up with physician, PONS not having clear instructions, etc.).
- 4-2: The person regularly participates in unscheduled and scheduled community activities to the same degrees as people not receiving HCBS (the reviewer found that the person went out 6 times in one year and 4 were haircuts and an associate stated probably because not enough associates on shift).
- 6-6: People have privacy in their home and service environments as appropriate to the situations (i.e., no curtains at bedroom windows at one IRA).
- 6-7: People have access to food at any time (the pantry at one IRA had less than 5 canned vegetables, 1 box of macaroni and cheese, 1 box of crackers, a jar of peanut butter, no snacks, and the refrigerator only had condiments and drinks).
- 8-11: Fire alarm and notification systems are operational and effective (fire alarm evacuation signal did not have a three-pulse temporal pattern) at one IRA. (This was also noted at 4 other IRA's but received Exit Conference Findings.)
- 8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards (at one IRA the sprinkler inspection was completed and found a valve supervisor device did not operate and the agency didn't ensure this repair was completed). (This was a Statement of Deficiency for 2 programs.)

Plans of Corrective Action (POCA) were completed for these Statements of Deficiency and approved by OPWDD.

B. <u>SELF EVALUATION/SELF SURVEYING:</u>

OPWDD's Site Protocol Manual, Person-Centered Protocol Manual, and Agency Protocol Manual have been shared with program management/leadership across the agency for their use in self-monitoring activities. The Quality Department completes reviews at program sites using a variety of tools including the OPWDD protocols and other forms developed over the years. Any identified needs for improvement will be addressed through a written process and the effectiveness of the actions will be verified by a designee of the Quality Department.

The Quality Director reports outcomes of internal monitoring to the Quality Improvement Committee and the Board of Directors.

Internal reviews of health/medical including Med Room Reviews continue. We continue to find missing documentation in all areas of tracking/monitoring, i.e., bowel tracking, fluid/food intake, vitals, etc.; missing GER's for ER visits/hospitalizations; Plans of Nursing Service (PONS) that are missing information; follow up missing/delayed information from appointments; medications that are discontinued/outdated. Results of reviews are sent to the program and the RN and plans of corrective action are required and followed up by the Quality Department.

C. INCIDENTS:

The Arc Allegany-Steuben takes the issue of reporting and investigating incidents very seriously. All associates are provided with training on abuse prevention and reporting, the Justice Center Code of Conduct, the responsibilities of mandated reporters, promoting positive relationships with people receiving supports, etc. This training starts with all new employees upon hire, during onboarding and within the first 90 days of hire. Associates are also trained annually. Additionally, retraining is provided on specific, focused information related to untoward events as necessary. The Board of Directors are also trained annually.

The Incident Review Committee (IRC) meets every 28 days and reviews all incidents including Reportable – Abuse/Neglect; Reportable – Significant; Serious Notable Occurrences; Minor Notable Occurrences; and incidents not under the agency's auspices (part 625 incidents). IRC reviews the incidents/investigations for thoroughness, recommendations/make recommendations, identify trends, etc.

Monthly, data on incidents is tracked and reported and shared with the Board of Directors and the Quality Improvement Committee for their awareness, review, and discussion.

The Arc Allegany-Steuben trends minor/internal incident reports on monthly basis and share with the executive team including:

1. Injuries of unknown incidents
2. Emergency Room Visits
3. Medication administration errors and medication procedure errors
4. The use of SCIP-R physical interventions
5. Falls for people supported
6. Abuse incidents

The Arc Allegany-Steuben strives to eliminate the use of SCIP-R physical interventions, promoting positive behavior interventions that are less likely to add trauma to crisis situations. We currently teach only the required SCIP-R core curriculum and some specialized personal interventions, no restrictive interventions are approved for use within our service environments.

Chapter Incident Review Annual Report:

On an annual basis, the Quality Department completes and submits the Annual Incident Trend Report that is required by OPWDD Part 624 regulations. This is a cumulative report of the year's results which includes trends as compared to previous years and makes recommendations for improvements, including training, policy or procedures, physical plant, and program supports. This report is shared with the Incident Review Committee, Quality Improvement Committee and the Board of Directors.

D. SATISFACTION LEVEL OF THE PEOPLE WE SUPPORT:

The Incredible Voice Group of Self-Advocates is supported to meet regularly and encouraged to provide feedback to the organization. Invitations to Incredible Voice meetings are shared to encourage attendance either in-person or electronically. Guests are invited to present

information on a variety of topics of interest, including review and feedback on agency policies affecting care and service delivery.

Satisfaction surveys are completed annually. These surveys are reviewed by the programs and will be used to increase quality and satisfaction of the people we support.

The Residential and Day Programs completed satisfaction surveys in 2025 with everyone in the program. Issues identified were addressed by the program and the person receiving support.

In 2025, Self Direction completed a survey and results were completed in November 2025 and got a 5.75% return of the 450 people receiving services.

E. SATISFACTION LEVEL OF ASSOCIATES:

We use a variety of methods to solicit feedback from associates regarding their satisfaction with employment and their ability to perform their job duties. All senior leadership, including the Executive Director, practice an open-door policy and provide access to cell phone numbers for access at any time.

The Marketing Department distributes a satisfaction and feedback questionnaire each year to all associates. The results are compiled, reviewed by executive management, and used to address concerns toward improving satisfaction. Executive management discussed trends and metrics that are worked into the Strategic Plan, i.e., communication was identified as an area of concern, and a communication committee was developed to monitor that metric on the associate satisfaction survey. In 2025, associates identified a desire for meaningful appreciation and recognition, transparent compensation practices, stable staffing levels, better orientation/ongoing training, improved equipment/vehicles/facilities, and stronger sense of teamwork across departments/programs.

In 2025, the Human Resources Department conducted stay interviews with randomly selected associates to monitor satisfaction and identify factors impacting retention. Feedback is documented, and any concerns are shared with the appropriate management team for timely follow-up. Moving forward, Human Resources will aim to complete stay interviews with at least 25% of active associates (not including per diem) annually and track year-over-year trends in satisfaction and retention. In 2025, Human Resources completed 115 stay interviews out of 572 budgeted FTE's or 20.1%. In 2026, Human Resources will complete 25% stay interviews.

The Human Resources Department also administers exit interviews through a standardized online survey sent to all departing associates. In 2025, 112 associates (not including per diem) exited the organization, and 39 completed the survey, resulting in a 33.9% completion rate. This was an increase over last year, which only had a 28% completion rate.

Additionally, 30-day and 90-day new hire surveys are sent to all newly hired associates. This survey is completed on the agency's Relias training platform and is built into the new hire training plan. Survey results are reviewed and Human Resources follows up with management when any concerns are noted. Human Resources will identify programs where trends indicate

recurring concerns and will notify the appropriate management to collaboratively develop a plan to address and resolve the issues identified. Some of these issues in 2025 were regarding needing more training.

F. **THE ARC NY QUALITY INDICATORS**

In October 2012, The Arc of New York Board of Governors passed that Chapters must provide information to The Arc of New York's Quality Standards and Oversight Committee (QSOC). In addition, the Arc New York State Office receives copies of the minutes of the Board meeting where data has been reviewed and the targets for improvement for the coming years have been detailed. The information is organized under three categories: General Program and Operation, Statements of Deficiency, and Incidents, and is collected on a Quarterly and Annual basis as follows:

General Program and Operation:

1. Number of full/part-time employees
2. Total number of unduplicated people served in all programs
3. Total # of unduplicated people served in OPWDD programs ONLY
4. Number of unduplicated people served ages 18-65 in all programs
5. Number of people residing in IRA
6. Number of people residing in Certified ICFs[1]
7. Number of people gainfully/competitively employed due to agency supports
8. Total # of full/part-time associates that have exited employment
9. Number of vacant FTE DSP positions (CFR 200 codes)
10. Number of budgeted FTE DSP positions (CFR 200 codes)
11. Total # of full and part time DSP
12. Total # of full and part time DSP's who exited
13. Total # of full and part time DSP's that exited within the first 180 days
14. Total # of full and part time DSP's that exited between 181-364 days
15. Number of vacant Frontline Management positions
16. Number of budgeted Frontline Management positions
17. Number of Frontline Management employees
18. Number of Frontline Management employees that have exited the position
19. Total # of Emergency Room (ER) visits for individuals residing in IRAs
20. Total # of Emergency Room (ER) visits for individuals residing in ICFs[1]
21. Total # of people residing in IRA's on 12/31
22. Total # of people residing in ICF on 12/31
23. Total # of full / part-time DSP's
24. Total # of full / part-time DSP's that have exited employment
25. Total # of full / part-time DSP's that have exited employment within first 180 days
26. Total # of full / part-time DSP's that have exited employment between 181-364 days of employment

Statements of Deficiency:

1. Number of OPWDD Bureau of Program Certification (BPC) surveys

[1] Not applicable, Arc Allegany-Steuben does not operate ICF's.

2. Number of OPWDD BPC reviews resulting in a formal Plan of Corrective Action (POCA)
3. Number of Office of Fire Prevention and Control (OFPC) surveys
4. Number of OFPC surveys resulting in a formal POCA

Incidents:

1. Total number of reportable incidents – Abuse & Neglect (14 NYCRR Part 624)
2. Total number of substantiated investigations of reportable incidents – Abuse / Neglect (14 NYCRR Part 624)
3. Number of injuries to individuals (significant and minor notable occurrences) (14 NYCRR Part 624)

G. QIP REVIEW AND APPROVAL PROCESS:

The Quality Improvement Plan will be reviewed and revised at least on an annual basis. The QIP will be presented to the Board of Directors for review and approval. Once approved by the Board of Directors, a Chapter Board Resolution adopting the plan will be completed and submitted to The Arc New York.

H. ACTION ITEMS:

Strategic Plan:

1. The agency's Strategic Plan for 2024-2027 addresses a lot of initiatives in areas such as Business Operations, Financial, Technology, Transportation, Facilities, Inclusion, Workforce, Service Referral/Enrollment, Home Enabling Technology, Vocational Services, and Residential Services. These initiatives are reported to the Executive Team on a quarterly basis. Move strategic plan cycle up and evaluate what has been accomplished to move us forward.

Action Items for Reviews:

2. Reviews (OPWDD/internal): There is a group reviewing the agency's Health/Medical policy and procedures to update/develop as needed. In 2025, 13 policies/procedures were completed. The group continues to meet every other week and has set a deadline to have all policies and procedures updated and/or developed by 6/30/2026.
3. The PONS procedure was updated in 2025. Due to continued issues with the PONS during internal and OPWDD reviews, the PONS Procedure will be reviewed again in 2026 to ensure that it is appropriate and covers all aspects of the July 2023 OPWDD Health and Safety Alert – PONS, 2003-01 ADM Registered Nursing Supervision, the PONS training for RN's, and OPWDD RN Training.

Action Items for Incident Reporting:

4. In 2026, the Quality Department and Human Resources Department will be collecting data on incident reports including the program, classification, prevention plans, recommendations, target/subject, persons receiving services, years of service for the target/subject, etc. Our intent is to determine how many times we are retraining people on procedures, service plans, etc. This data will be reviewed quarterly and shared with Program Leadership.
5. In 2026, the Quality Department will review and update as needed the 624 Policies and Procedures and orientation/annual training for incident reporting by 9/30/2026.

6. In 2025 we identified a number of incidents involving driving concerns including speeding, driving while on the cell phone, etc. In 2026, we will work on updates to driving procedures and increased training for all associates.
7. Residential Program is working on a project to improve associates training in areas such as cleaning (checklists), program orientation/training, RCS format, Associate Advocate training, one page profiles, etc. The project is being completed by a group of associates in all levels of Life Coaches, the Associate Directors, Directors, QA, and COO.

Action Items for Service Satisfaction Surveys:

8. In 2025, Self Direction completed a survey and results were completed in November 2025 and got a 5.75% return of the 450 people receiving services. Actions taken by the Self-Direction program will be: Increase Self-Directed program satisfaction survey returns in 2026 to 20%.

Action items will be reviewed on a quarterly basis and any updates/changes will be made at that time.

QIC activities will be shared with the Board on a quarterly basis (in the Board Report to the Board and whatever other way the Board requests).