CENTER FOR SOCIAL CHANGE

We Change Lives

Center for Social Change

QUALITY ASSURANCE PLAN

JANUARY - DECEMBER 2025

ASPIRE to Excellence®

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ACCREDITED

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EXECUTIVE SUMMARY

The Center for Social Change (CSC), a private, non-profit organization established in 1993, provides various services for adults and children with developmental and medical disabilities throughout Maryland. CSC operates out of Elkridge, Maryland, serving Baltimore, Howard, and Anne Arundel Counties. Services include Community Housing, Adult Medical Daycare, Employment Services, Vocational Programs, and Day Habilitation Programs.

2025 HIGHLIGHTS

Center for Social Change successfully completed its fifth CARF accreditation survey in 2023 and was awarded a three-year accreditation across all programs, including Community Housing for adults and children, Community Supported Living Arrangements (CSLA), Assisted Living, Employment Services, Vocational and Day Habilitation, and Adult Medical Daycare. In 2025, the Board of Directors reviewed organizational outcomes and progress to ensure continued alignment with CARF standards. Center for Social Change is currently preparing for its next CARF accreditation survey scheduled for 2026.

PROGRAM EXPANSION

Center for Social Change operates **40** group homes/assisted living residences in Randallstown, Windsor Mill, and the Laurel/Savage area. At the end of the 2025 Calendar Year, 146 persons were supported in CSC's Community Housing and Assisted Living Program, and 88 persons were supported in our Day Habilitation/CDS/SE programs. In 2025, there were 13 admissions and 10 discharges, mainly in the Children's Program.

COMMUNITY EDUCATION, INVOLVEMENT AND OUTREACH

In 2025, CSC continued to provide exceptional services and support through DDA's Community Pathways, Community Supports, and Family Supports programs. Additionally, the following services and supports have been approved by DDA:

- **Family Peer and Mentoring Supports**
- **Community Development Services**
- **Family Caregiver Training and Empowerment Services**
- **Nursing Services (Health Case Management)**
- **Behavioral Support Services**

As a nonprofit organization, CSC recognizes the importance of staying engaged and relevant within the community it serves. This commitment is reflected in CSC's active involvement in local initiatives and its dedication to raising awareness about the needs of the individuals it supports.

CSC remains a proud member of several professional organizations, including:

- Maryland Association of Community Services
- Maryland Council of Directors of Volunteer Services
- Maryland Association of Nonprofits (MANO)
- Maryland Works
- Disability Sports USA
- Liberty Road Business Association (LRBA)
- Liberty Road Community Council (LRCC)
- Fieldstone Community Association
- Maryland Chamber of Commerce
- Baltimore County Chamber of Commerce
- Howard County Commission on Disability Issues (CDI)

CSC also takes pride in participating in quarterly and annual meetings of the LRBA and LRCC, further solidifying its connection to the local community. As an annual sponsor of the Liberty Road Tree Lighting Ceremony at Randallstown Gateway Park, CSC continues to support this cherished event, even during times when the individuals served by CSC are unable to attend in person.

Enhancing Community Integration

CSC remains steadfast in its mission to promote community integration for the individuals it serves. In 2025, CSC organized a variety of enriching activities to foster connection, joy, and inclusion. These activities included:

- Vacations to Ocean City
- Attendance at Disney on Ice, Six Flags, Monster Truck Jam, concerts, and sporting events
- Celebrations at various holiday parties

Through these efforts, CSC continues to create opportunities for individuals to thrive, participate fully in their communities, and enjoy meaningful life experience

STAFF EXPANSION:

CSC has demonstrated its continued commitment to developing a robust, skilled workforce to provide the highest quality standards. During the past year, 332 new direct support professionals have been hired to help CSC best serve the individuals who have chosen CSC as their provider of choice.

In addition to these new hires, 8 new administrative staff were hired in several departments in 2024. Operations increased staff in the Medical Day Care, Day Habilitation Programs, and Community Housing Program. Currently, CSC has 635 total direct support professionals (287 Adult Residential DSPs, 171 Children's Residential DSPs, 79 Day Services DSPs, 11 Adult Medical Day DSPs, 8 Assisted Living DSPs, and 75 Administrative Staff). CSC also has contracted with outside clinical staff to provide services to individuals.

INCIDENT REPORTING

Reportable/Non-Reportable Incidents January 1, 2025 – December 31, 2025

Between January 1, 2025 and December 31, 2025, 38 total incidents reportable with an A7 have been reported in the Residential Program & 1 incidents in the Employment Services/Vocational Program. The incidents occur with the frequency noted below for the following categories:

Residential Reportable Incidents:

Abuse	4
Death	2
Hospital/ER	22
Hospital/Psychiatric	1
Neglect	1
Injury	6
Other	0
Police	2
Restraint	0
Sexual Abuse	0
AWOL	0
Theft of Individual's Property or Funds	0
Total	38

Employment Services/Voc Reportable Incidents:

Abuse	0
Death	0
Hospital/ER	1
Hospital/Psychiatric	0
Neglect	0
Injury	0
Other	0
Police	0
Restraint	0
Sexual Abuse	0
AWOL	0
Theft of Individual's Property or Funds	0
Total	1

Internally Investigated incidents:

A total of 76 internally investigated incidents occurred during the calendar year 2025 in the Residential Program & 0 incidents in the Employment Services/Vocational Program; these were reported on the A5 form. A breakdown of the types, and frequency of occurrences, is shown below:

Residential Internally Investigated incidents:

Hospital/ER/Psychiatric	76
Injury	0
Police	6
AWOL	0
Other	0
Total	**76**

Employment Services/Voc Internally Investigated incidents:

Hospital/ER/Psychiatric	0
Injury	0
Police	0
AWOL	0
Other	0
Total	**0**

Generally, the distribution pattern of internally investigated incident types is quite similar to that found in the Reportable Incident list- that is, "Hospital visits" and "Police" visits occur with the greatest frequency in both the Reportable Incident list and the internally investigated incident list. This is, perhaps, not unexpected.

Hospital/ER visits were the largest incident category. These visits are due to medical issues expected of the individuals involved. Examples of ER visits include seizures, wound care, g-tube care, behavioral, etc. The Standing Committee *(see Appendix B for Standing Committee details*) reviews all incidents to determine whether the responses made by staff and the agency were appropriate and whether any systemic changes need to be made to avoid such incidents in the future. The number of incidents is more significant as some are counted above for both investigated and internally investigated under both categories. However, the incident was reported by the highest level of reporting need in PCIS2.

QUALITY ASSURANCE OBJECTIVES 2026

Center for Social Change has identified the following objectives for 2026. These objectives are based on the reviews from OHCQ and suggestions from the Quality Assurance Committee.

MEDICAL /CLINICAL SERVICES

1. Maintain a 98% compliance rate to completing scheduled and referred appointments.
2. Maintain a low rate of errors for all major medication errors, at a level not to exceed 3% in any given quarter and not to exceed 5% yearly.
3. Achieve a rate of occurrence of MAR charting/ procedural errors (e.g.- Weight not documented, BP not documented, missing start dates, circles on the front not being explained on the back, medications discontinued appropriately with a reason on the back of MAR) so as not to exceed 3% for any given quarter.
4. Achieve a rate of 100% of the completed consult forms to be uploaded to the THERAP online documentation system.
5. Achieve a rate of 95% in Nursing / Health Case Management and Delegation for interim follow-up evaluation after hospitalization.

PERSON CENTERED PLANS & CARE

(ADULT MEDICAL DAY, COMMUNITY HOUSING, ASSISTED LIVING, & EMPLOYMENT, DAY & VOCATIONAL SERVICES):

1. Achieve 100% of all IPs being up-to-date in Community Housing, Assisted Living, Employment Services & Day Habilitation/Vocational Services.
2. Achieve 100% of IP implementation by ADP date.
3. Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare.
4. Achieve 100% of Person-Centered care plans completed for Rising Sun Assisted living units yearly.
5. Achieve 100% of all MANDT Behavior support plans being reviewed and updated annually in Community Housing, Employment Vocational & Day Habilitation Services.
6. Achieve 100% of Behavior Plan implementation by ADP date and 100% revisions implemented within 3 days of team and Standing Committee approval.
7. Individuals will submit at least 10 job applications in our supported employment program per month and secure 5 jobs per year.

HUMAN RESOURCES

1. Achieve a turnover rate of no more than 24% throughout the year.
2. Achieve a completion rate of 95% for DDA-mandated/Core training for all staff during the current calendar year.
3. Achieve and maintain a completion rate of 97 % performance evaluations completed

OPERATIONS/ MAINTENANCE:

1. Maintain at least a 100% rate of compliance to completion of fire and disaster drills.
2. Maintain turnaround at 85% for addressing maintenance request within 24-48.
3. Update the Maintenance database with no more than 30 days of entry missing.

TECHNOLOGY / HEALTH INFORMATION MGMT:

1. Utilizing THERAP at least 80 % for all person-served demographics, and Person-Centered Plans
2. Utilizing STED 85% for ALU meetings minutes

COMMUNITY RELATION AND ADVOCACY:

1. Increase family member satisfaction to at least 95%.
2. Increase Stakeholder satisfaction to at least 99%
3. Increase Staff Personnel Satisfaction to at least 90%
4. Increase at least 10% in return rate among Staff/Stakeholders and family member satisfaction survey.

QUALITY ASSURANCE REPORT 2025

CSC's Quality Assurance report covers the 2025 calendar year and focuses on the objectives that were identified in the previous year's QA Plan. In many cases, 100% of a given sample set was analyzed. However, due to the large number of program participants and available data, data for some analyses were collected utilizing randomly defined samples. Using information available in agency databases such as THERAP and STEDS, written reports, QA audits, individual files, stakeholder surveys, etc., objective data were collected and analyzed for selected program areas.

Quality Assurance Objectives for Calendar Year 2025

Medical/Clinical Services:

1. Maintain a 98% compliance rate to completing scheduled and referred appointments.
2. Maintain a low rate of errors for all major medication errors, at a level not to exceed 3% in any given quarter and not to exceed 5% yearly.
3. Achieve a rate of occurrence of MAR charting/ procedural errors (e.g.- Weight not documented, BP not documented, missing start dates, circles on the front not being explained on the back, medications discontinued appropriately with a reason on the back of MAR) so as not to exceed 3% for any given quarter.
4. Achieve a rate of 100% of the completed consult forms to be uploaded to the THERAP online documentation system.
5. Achieve a rate of 95% in Nursing / Health Case Management and Delegation for interim follow-up evaluation after hospitalization.

Person-Centered Plans & Care:

(ADULT MEDICAL DAY, COMMUNITY HOUSING, ASSISTED LIVING, & EMPLOYMENT, DAY & VOCATIONAL SERVICES):

1. Achieve 100% of all IPs being up-to-date in Community Housing, Assisted Living, Employment Services & Day Habilitation/Vocational Services.
2. Achieve 100% of IP implementation by ADP date.
3. Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare.
4. Achieve 100% of Person-Centered care plans completed for Rising Sun Assisted living units yearly.

5. Achieve 100% of all MANDT Behavior support plans being reviewed and updated annually in Community Housing, Employment Vocational & Day Habilitation Services.
6. Achieve 100% of Behavior Plan implementation by ADP date and 100% revisions implemented within 3 days of team and Standing Committee approval.
7. Individuals will submit at least 10 job applications in our supported employment program per month and secure 5 jobs per year.

Human Resources:

1. Achieve a turnover rate of no more than 24% throughout the year.
2. Achieve a completion rate of 95% for DDA-mandated/Core training for all staff during the current calendar year.
3. Achieve and maintain a completion rate of 97 % performance evaluations completed

Operations/Management:

1. Maintain at least a 100% rate of compliance to completion of fire and disaster drills.
2. Maintain turnaround at 85% for addressing maintenance request within 24-48.
3. Update the Maintenance database with no more than 30 days of entry missing.

Technology/Health Information Management:

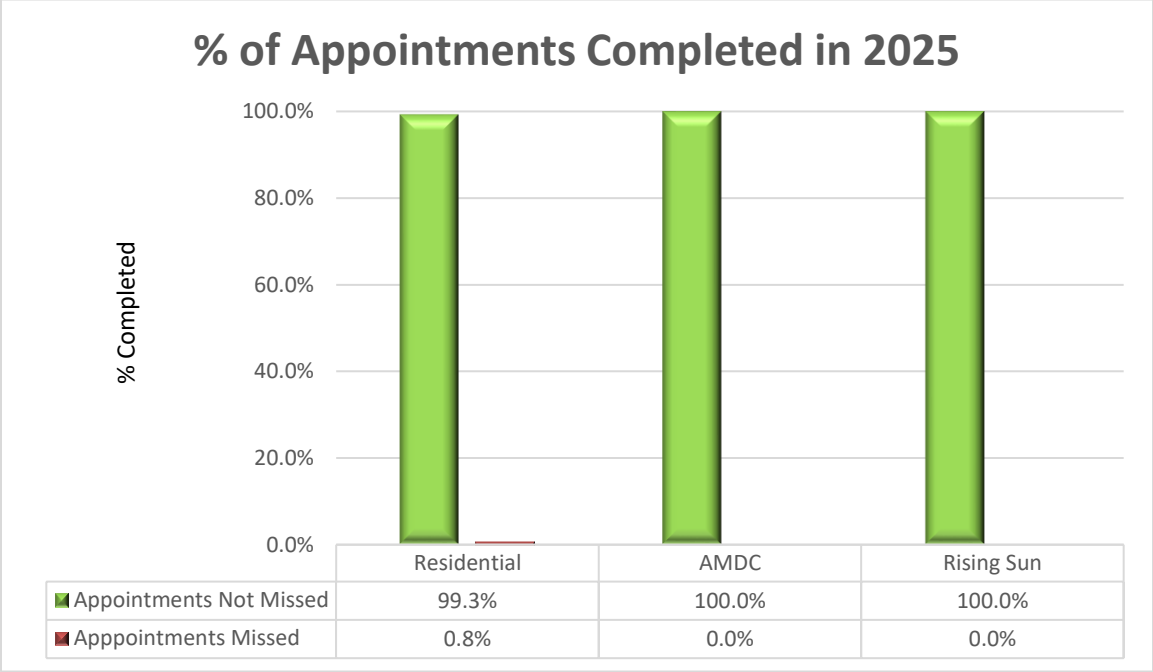
1. Utilizing THERAP at least 80 % for all person-served demographics, and Person-Centered Plans
2. Utilizing STED 85% for ALU meetings minutes

Community Relations and Advocacy:

1. Increase family member satisfaction to at least 95%.
2. Increase Stakeholder satisfaction to at least 99%
3. Increase Staff Personnel Satisfaction to at least 90%
4. Increase at least 10% in return rate among Staff/Stakeholders and family member satisfaction survey.

Objective #1: Maintain at least a 98% rate of compliance to the completion of scheduled and referred appointments. (No more than 2% will be missed)

Data was collected for each individual throughout the year by the Quality & Compliance Data Analyst. In total 6150 Residential & 245 AMDC appointments were performed throughout the 2025 calendar year. All Rising Sun appointments are handled by AMDC, resulting in 0 appointments for Rising Sun.



Summary Results/Discussion:
The results indicate that the goal of 98% compliance rate to completion of scheduled medical appointments was met for the Residential program with **99.3%**. A total of 6150 Residential & 245 AMDC appointments were scheduled from Jan – Dec 2025, and 98 were missed. In 2024, we had a compliance rate of 98.4%. In 2023, we had a compliance rate of 98.6%, and in 2022, we had a compliance rate of 98.2%. Compared to previous years, we have increased slightly on the rate of compliance.

An assessment of the primary causes for which appointments were missed was completed. For those missed appointments for which a reason was identified, there were a few primary reasons that they were missed:

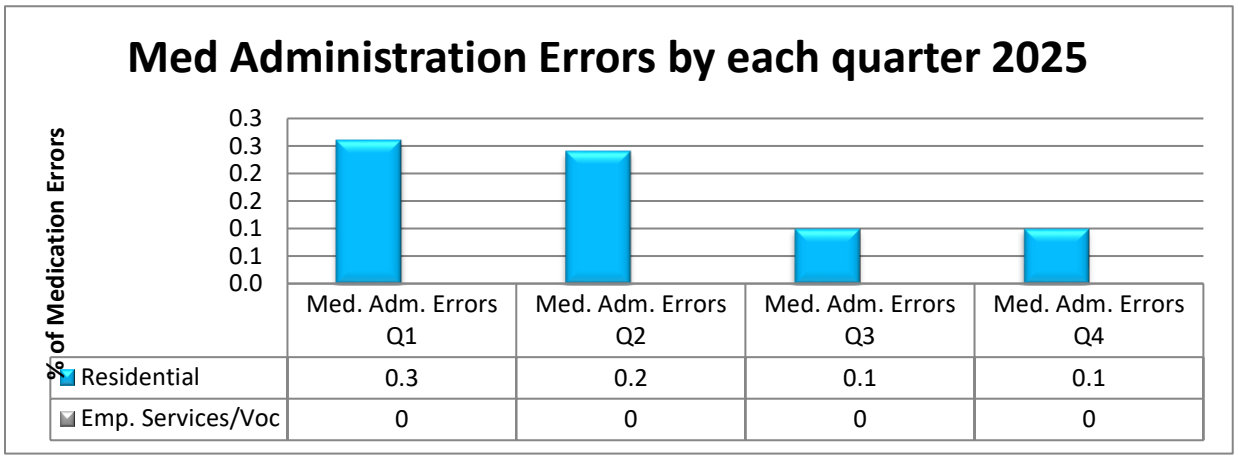
- Cancellations by the medical provider's office
- The Person Served went to the apt and refused to cooperate at the Doctor's Office.

Plan of Action:

Program Managers responsible for submitting medical appointment status reports have been advised that they are required to provide documented, valid justification for any missed medical appointments. The most frequently identified cause of missed appointments is provider-initiated cancellations, which are outside of CSC's control. To promote consistency and accuracy in scheduling documentation, all medical appointments are entered into Therap, the designated medical scheduling system, with the appointment time recorded as 30 minutes prior to the scheduled provider visit. Quality Assurance staff conducted a comprehensive review of medical appointment reports for each individual served, during which all referrals were identified. A subsequent review was completed to determine whether referred appointments were scheduled and successfully completed.

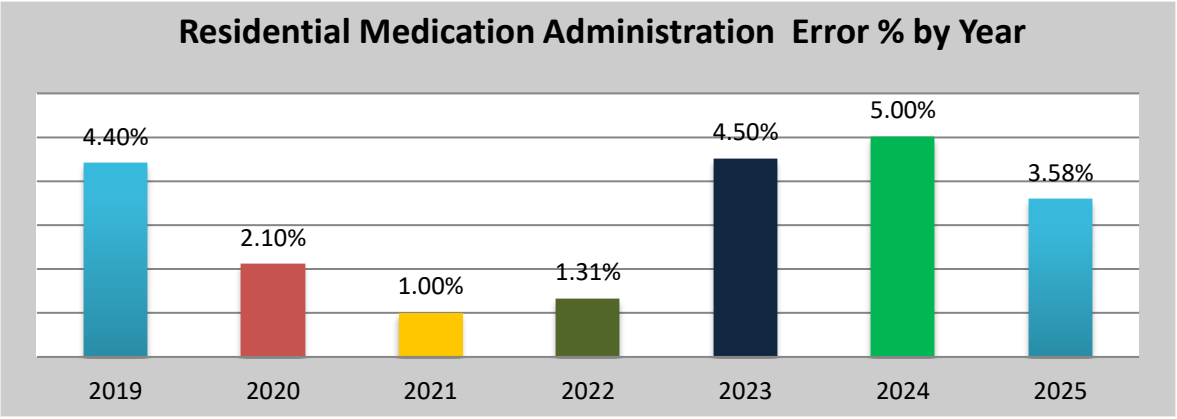
Objective #2: Maintain the low rate of major medication errors, at a level not exceeding 3% in any given quarter and not to exceed 6 % yearly.

CSC has continued its contract with Dimensional Health Care Associates for nursing delegation. As per their delegation policies, Delegating Nurses ensure proper documentation and tracking of medication errors as part of a quality assurance plan. The graph indicates the medication administration error rate for the error category "Major Errors." This error category comprises of failures by staff to give medications as prescribed. It is our goal to reach at a level not to exceed **3%** medication errors in any given quarter



Results/Discussion:

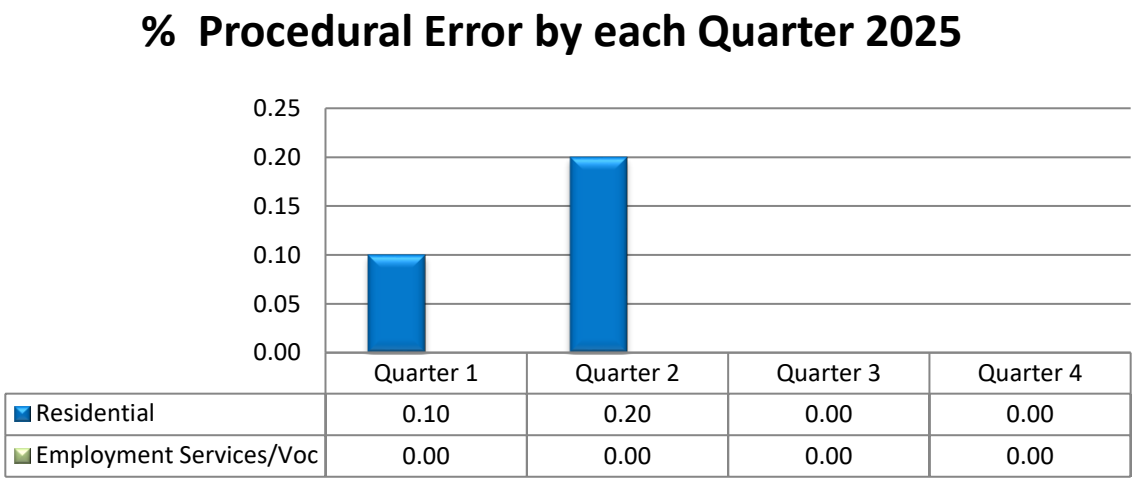
During the reporting period of January 1, 2025, to December 31, 2025, the results indicate that the goal of a 3% or less error per quarter rate was met for all four quarters. The total yearly percentage for the Residential Program is **5%** and the total for the Employment Services/Vocational Program is **0%**. An annual comparison shows a small but insignificant increase in the error percentage from last year. This small increase is not a concern as we have not surpassed our 6% error limit. We will continue to implement our Medication Administration procedures.



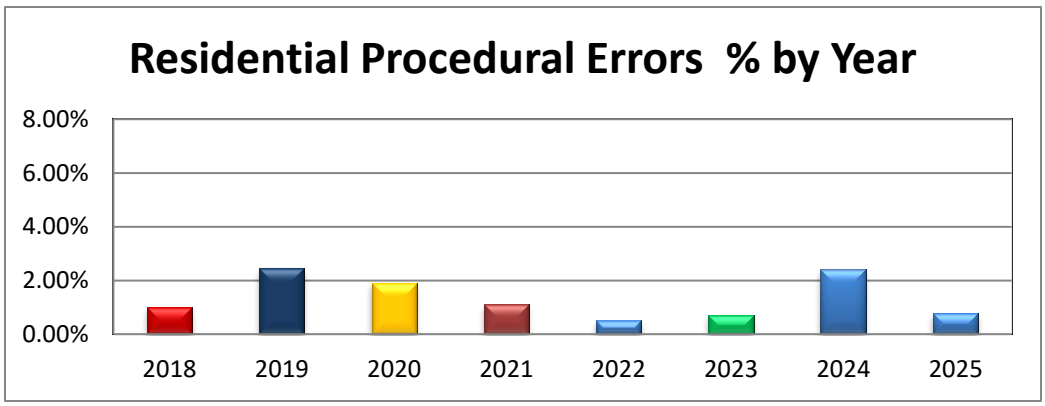
Plan of Action:
CSC has established good quality processes and risk-management strategies to prevent medication errors. Coordinators will continue to be required to monitor medication administration at each of their daily house visits. The Quality Assurance team will continue to perform ongoing audits by visiting each house approximately 4-5 times a month. Delegating nurses will visit the homes every 45 days. Also, Med Rite performs its reviews 4 times a month. CSC will also monitor the yearly percentage of medication errors not exceeding 6 % per year.

Objective #3: Maintain a rate of occurrence of MAR procedural errors to be at most 3% for any given quarter.

As per delegation Policies, nurses are delegated to ensure proper documentation and tracking of procedural errors as part of a quality assurance plan.



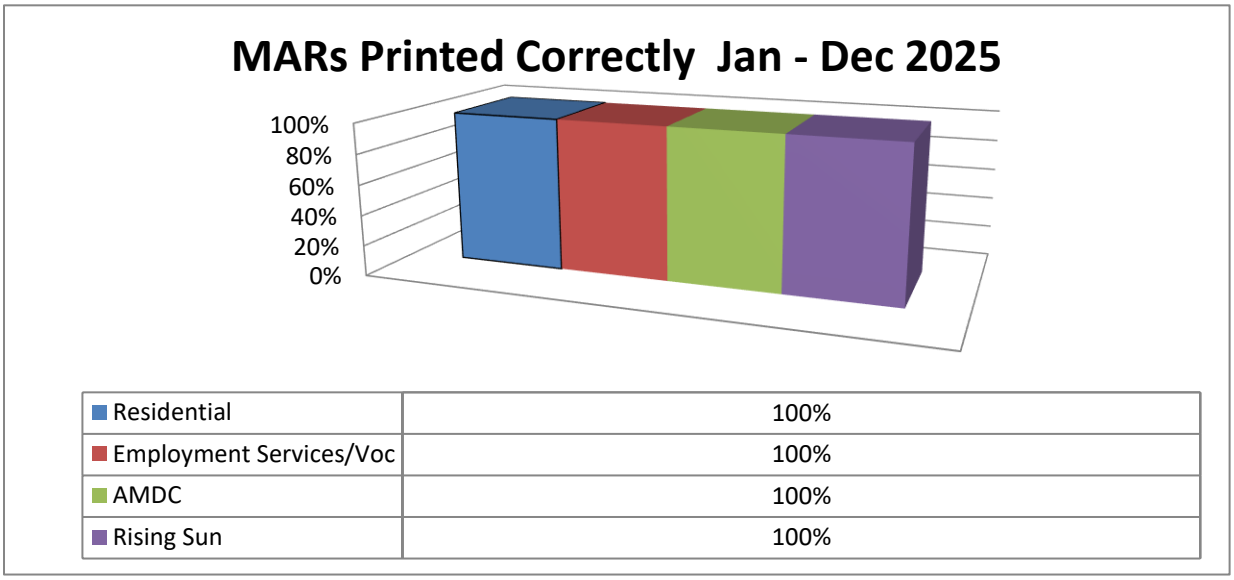
Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, the goal of a less than 3% rate of occurrence of Procedural Errors for all quarters was met, and procedural errors were noted for all four quarters was 3% total for the Residential Program & 0% for the Employment Services/Vocational Program during 2025.



Plan of Action:
No changes are planned, as the goal was met and significant improvements were made compared to the previous calendar years. We will continue to implement the current procedures.

Objective #4: Maintain a 100% rate of MARs being printed with all the required information (including individual's sex, DOB, and delegating Nurse's name)

CSC is partnered with Care One Pharmacy to serve our individuals' medication needs. They continue to increase their involvement in patient care activities provided to communities. Proper and accurate documentation is an absolute necessity to them.



Residential	100%
Employment Services/Voc	100%
AMDC	100%
Rising Sun	100%

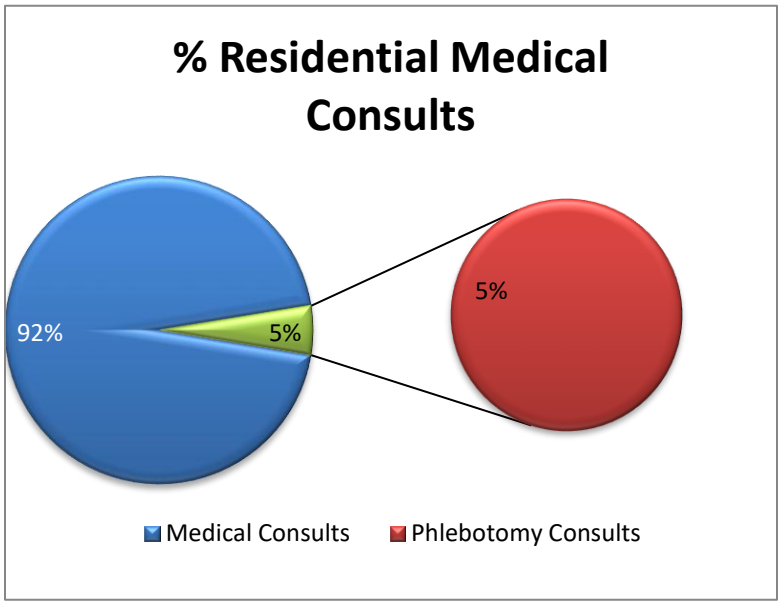
Results/Discussion:

During the reporting period of January 1, 2025, to December 31, 2025, 100% of MARs were printed without errors and with the required information. During 2024, four quarterly audits were completed on random individual medical binders. All four audits completed were on different information such as the person served correct Name, DOB, Gender, Physicians name, Delegating Nurse name, allergies, etc. Clinical and QA staff audits have been completed and can be located in the QA audit section. In 2023 and 2024, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.

Plan of Action:
The Program Managers and Clinical Department will continue to work with Care One Pharmacy to monitor new printed MARs each month to ensure all required information continues to be reflected. Quality assurance audits will be completed planned or randomly, and an analysis report will be submitted to the Quality Assurance Committee.

Objective #5: Achieve a rate of 100% of the completed consult forms to be uploaded in the Therap online documentation system.

Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, 100%. Based on the audit, 7032 completed medical appointment consult forms were successfully uploaded in Therap for the Residential Program. Phlebotomy consults totaled 380 The total number of consults uploaded in Therap was 7412. In 2023 and 2024, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.



Plan of Action:

In 2025, our Clinical Specialists' biggest challenge continued to be receiving the completed consultation forms from the DSP after an appointment. Program Managers will help expedite the return of consults. Clinical staff will continue to process and upload consultation forms after each appointment. Our Quality Assurance team will continue to monitor the completion and upload of the consultation form in the Therap online documentation system.

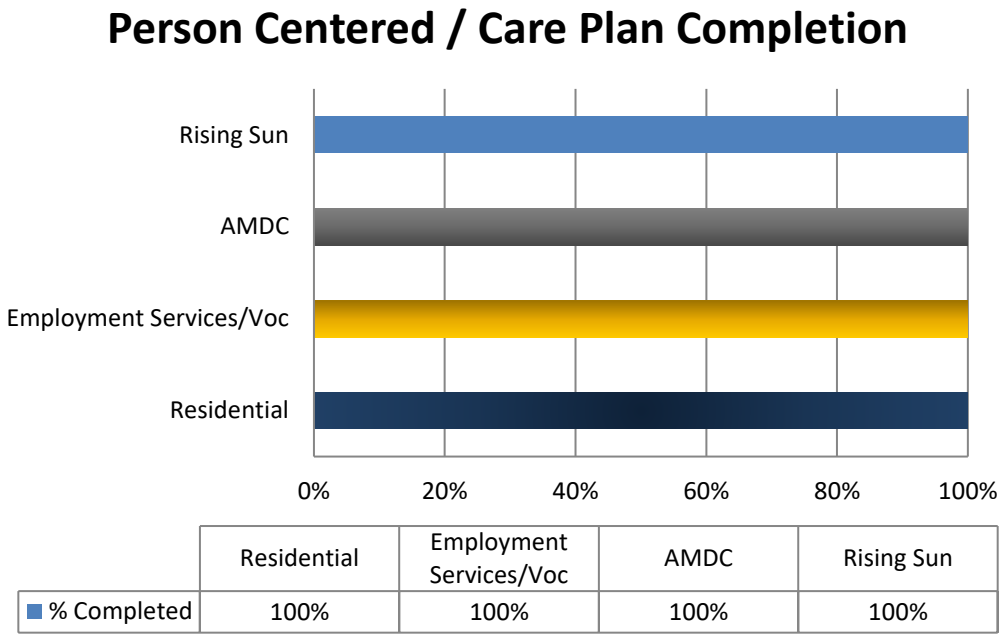
Objective #6: Achieve a rate of 95% in Nursing/Health Case Management and delegation for interim follow-up evaluation after hospitalization.

Results/Discussion:

During the reporting period of January 1, 2025, to December 31, 2025, 98% of all emergency room visits/hospitalizations have had a follow-up completed by the delegating nurse within 48 hours for the Residential Program. In 2025, 225 emergency room visits/hospitalizations required follow-up from the Delegating Nurse. The 5 visits that were not completed were due to a DN suddenly quitting & staff not notifying DHCA. All missed follow-ups were rescheduled and completed at a later time in 2025. In 2024, we had a 96.6% follow-up rate so, we have seen an improvement in our compliance rate.

Objective #7: Achieve 100% of all Person-Centered plan's being up to date in AMDC, Community Housing, Assisted Living, Employment & Vocational Day Habilitation Programs.

The Quality & Compliance Data Analyst is responsible for gathering the data during Program meetings where the program specialist reports how many Person-Centered plans are due, completed, or upcoming. In 2025, all Person-Centered plans were audited to determine if the current plan was implemented within the required year from the date of the last plan. A database is kept up to date to identify when the last planning meeting was held and when the next one is due. Program Specialists update that database once the planning meeting has occurred. During the quality assurance monthly meeting, the status of the annual meeting is discussed, including any delays or cancelations. The graph below shows the results of that audit:



	Residential	Employment Services/Voc	AMDC	Rising Sun
% Completed	100%	100%	100%	100%

Results/Discussion:

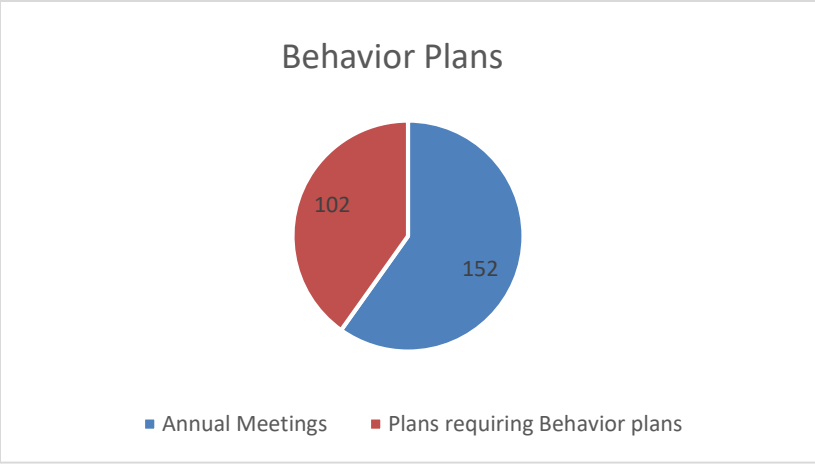
During the reporting period of January 1, 2025, to December 31, 2025: 113 Individual Plans were completed for Residential Program, 62 Individual Plans for Employment Services/Vocational, 50 Care Plans for Adults Medical Day, and 51 Care Plans for Rising Sun Assisted Living. CSC completed these within 365 days. During the QA meeting, the program specialists provide the QA Compliance Data Analyst with a monthly schedule for individual plans and implementation. In 2023 and 2024, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.

Plan of Action:
One barrier we faced in 2025 was completing the annual plans on time via teleconferences. Many other agencies are continuing to meet virtually rather than in person; however, scheduling for teleconferences can be challenging, and meeting times can often be overlooked. We believe that in-person meetings are most valuable for the people we serve. Our Program Specialists will continue to encourage the support team to hold in-person Annual IP meetings to ensure meetings continue to be held on time.

Objective #8: Achieve 100% of all Behavior Support Plans being reviewed and updated annually in Community Housing, Employment Vocational, and Day Habilitation services.

Results/Discussion:

During the reporting period of January 1, 2025, to December 31, 2025, 100% of behavior plans were reviewed and uploaded, and the goal was met. In preparation for each individual's annual meeting, the behavior plan is reviewed with the behavioral data to complete the yearly draft before the meeting and discuss it at the annual meeting. One barrier is obtaining the review and signature from court-appointed guardians for implementation, as many meetings are not held in person but instead via teleconference. Of the 152 annual meetings, 102 required behavior plans to be reviewed and updated at the time of the meetings. In 2023 and 2024, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2026 as well.

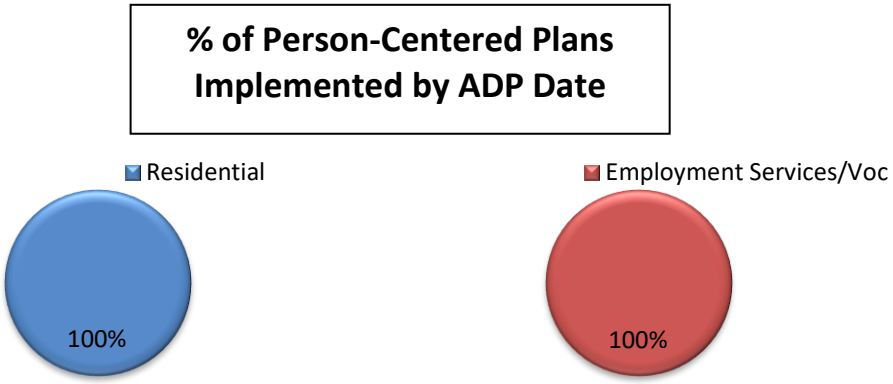


Objective #8 part 2: Achieve 100% of Behavior Plan implementation by ADP date and 100% revisions implemented within 3 days of team and Standing Committee approval

Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, 100% of Behavior Plans were implemented by their ADP date, and 100% of Behavior Plan revisions were implemented within three (3) days of approval by the interdisciplinary team and Standing Committee. No delays or outstanding Behavior Plans were identified during this reporting period. These results demonstrate full compliance with established timelines and regulatory requirements.

Plan of Action:
Given the organization's continued success in meeting this goal, **no corrective action is required at this time**. The organization will maintain current practices, including ongoing staff training, routine monitoring of Behavior Plan implementation timelines, and oversight by the Quality Assurance and Standing Committees. Data related to Behavior Plan implementation will continue to be reviewed quarterly to ensure ongoing compliance and to promptly address any identified barriers. Should trends indicate a risk to compliance, corrective actions will be implemented immediately to maintain 100% adherence.

Objective #9: Achieve 100% of IP Implementation by the ADP date.



Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, 100% of all Individual Plans (IPs), including those within the Children's Programs which are required to be implemented within 20 days, were implemented by their ADP date. A total of 113 annual person-centered plans were implemented for the Residential Program and 62 for Employment Services/Vocational Services, with 0 IPs outstanding. In 2023 and 2024, the compliance rate for this goal was 100%. This level of compliance was maintained in 2025, demonstrating continued consistency and adherence to implementation timelines.

Plan of Action:
One of the barriers identified is receiving signed documentation from the DSS guardians. Program Specialists will continue to schedule the implementation date once the IP date is confirmed with the team. They will continue to follow up via emails and phone calls to ensure they receive all necessary signatures from all legal guardians.

Objective #10: Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare

Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, 100% of all care plans were completed and implemented. All care plans were completed and implemented within 10 days, and the six-month reviews were completed and implemented within 5 workdays. In 2023 and 2024, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.

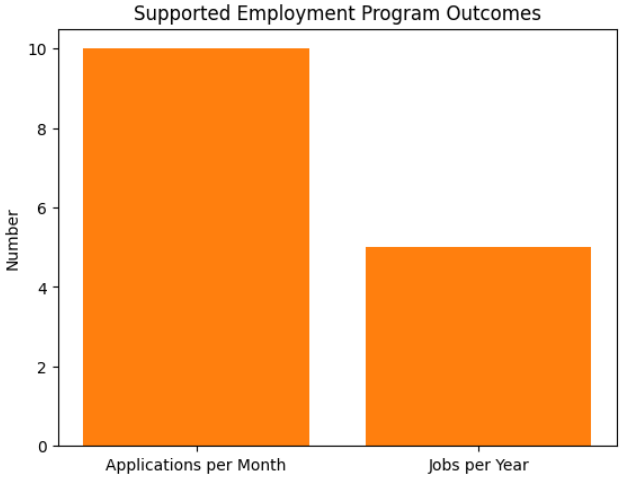
Plan of Action:
The Registered Nurse will continue to hold care plan meetings, either in person or virtually, to ensure that all care plans are completed and implemented as required.

Objective #11: Achieve 100% of Person-Centered care plans completed for Rising Sun Assisted Living units.

Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, 100% of all Person-Centered care plans were completed. The Assisted Living Units for Center for Social Change provided services for 51 adults through the waiver for older adults. All care plans were completed and implemented within 10 days, and the six-month reviews were completed and implemented within 5 work days.

Objective #12: Individuals will submit at least 10 job applications in our supported employment program per month and secure 5 jobs per year.

Results/Discussion:
During the review period, individuals participating in the Supported Employment program actively engaged in the job search process, with the majority meeting or exceeding the benchmark of submitting at least 10 job applications per month. Employment staff provided individualized support with job identification, application completion, interview preparation, and employer follow-up. As a result of these efforts, participants collectively secured **five competitive, integrated employment placements** during the year, meeting the annual employment outcome target. Ongoing tracking indicated improved consistency in application submission and increased participant confidence in navigating the job search process independently.



Plan of Action:

The results indicate that the established goal effectively promoted consistent engagement in employment-related activities and contributed to positive employment outcomes. Regular application submission increased exposure to competitive employment opportunities and strengthened job-readiness skills among participants. While the annual job placement target was achieved, variability remained in individual application completion rates due to factors such as transportation barriers, health considerations, and employer responsiveness. Moving forward, the program will continue to strengthen employer partnerships, expand job

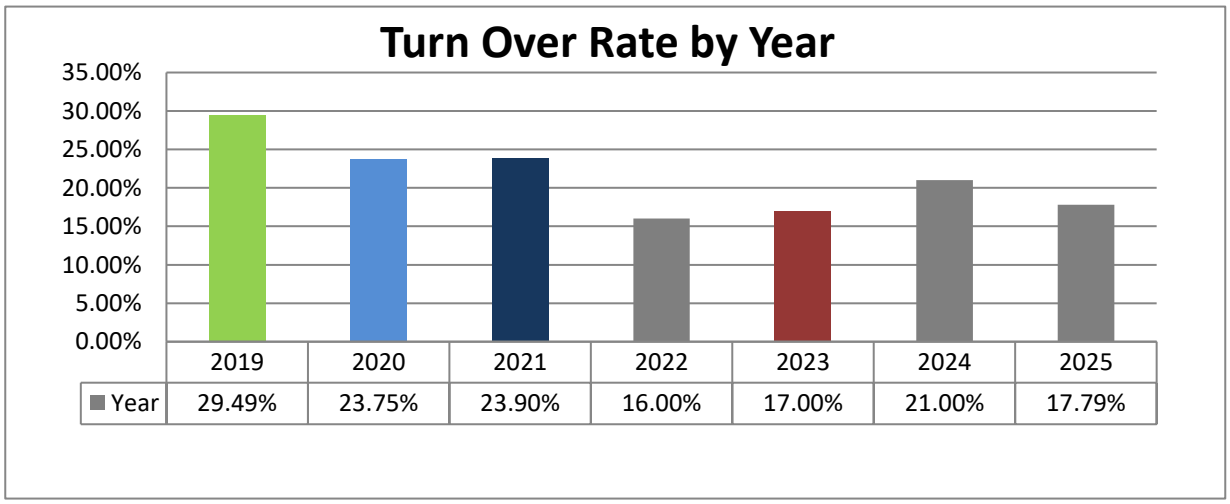
development efforts, and provide additional supports to individuals requiring increased assistance to sustain consistent application activity. These strategies are expected to further enhance employment outcomes while maintaining person-centered, individualized support.

Objective #13: Maintain a turnover rate of no more than 25% throughout the calendar year 2024

Turnover is defined as anyone leaving the job for any reason, regardless of that staff person's tenure. The turnover rate was determined by identifying the average number of active staff (i.e., those who received a paycheck) during 2025, calculating the number of staff members who left employment during 2025, and dividing those numbers to get turnover rate.

The number of staff personnel that received a paycheck is 635. The number of staff members leaving employment during the calendar year was 113.

Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, there was a 17.79% staff turnover rate. The goal of maintaining a turnover rate of at most 25% was met by 7.21%. There was a 3.21% increase from last year, which was not significant.



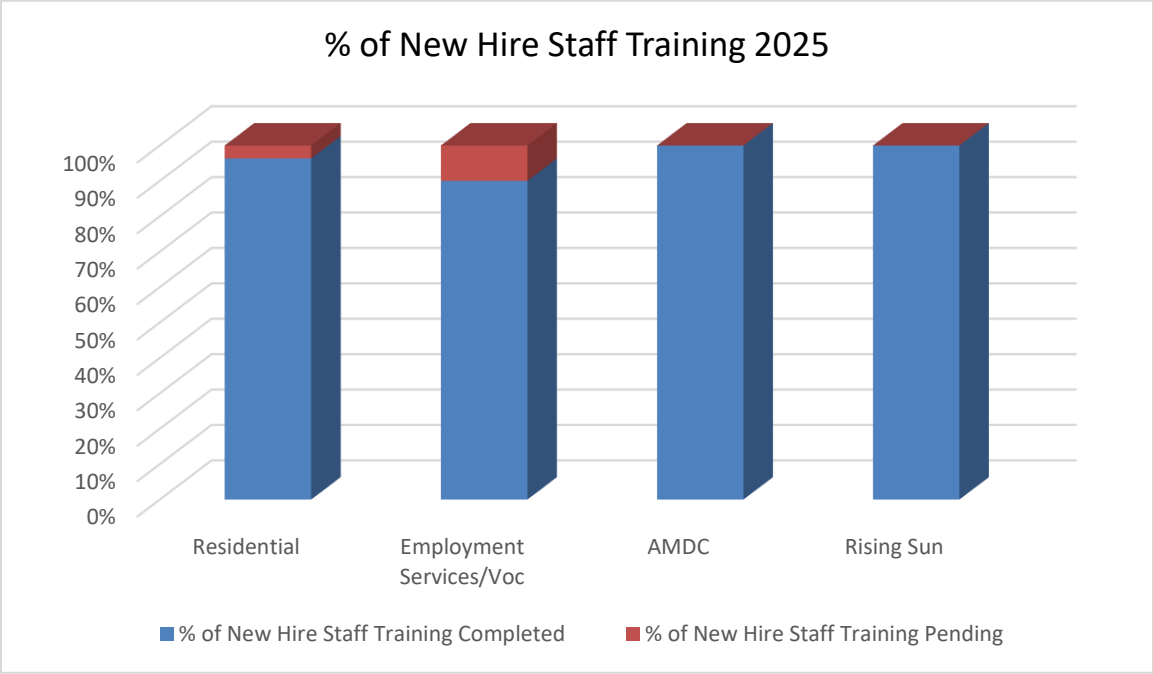
Plan of Action:
To maintain lower turnover rates, Center for Social Change implemented several incentives. We increased the starting salary for DSP staff to a very competitive rate and offered sign-on bonuses to

employees who stayed past the probationary period. We also have yearly employee appreciation parties to help boost morale.

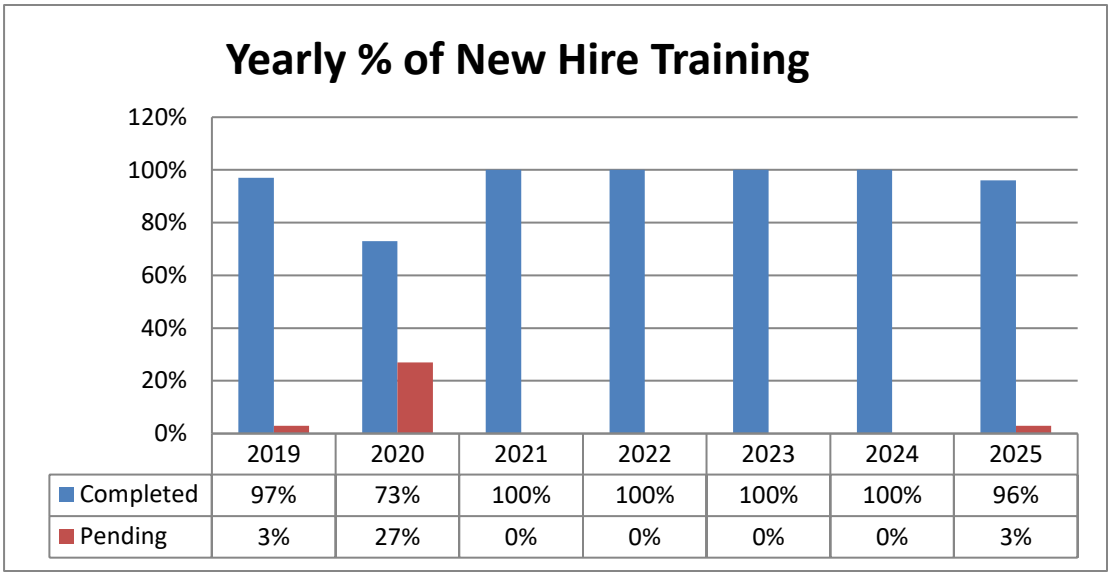
Barriers to lowering the staff turnover rate further include employees preferring work-from-home positions, unemployed persons receiving unemployment benefits, and DSPs not willing to adhere to Center for Social Changes' strict Awake Overnight Policies. We will continue all of our employee benefits into the new year.

Objective #14: Achieve a completion rate of 95% for DDA-mandated/Core training for all staff hired during the calendar year 2023

Newly hired staff are required to complete a set of DDA-mandated training within 3 months of their hire date. To determine the percentage of such training which were completed within the required time frame, an audit of HR files was completed to identify those staff who were: a) hired during 2025 and b) who would have been required to complete DDA-mandated training by December 31, 2025.

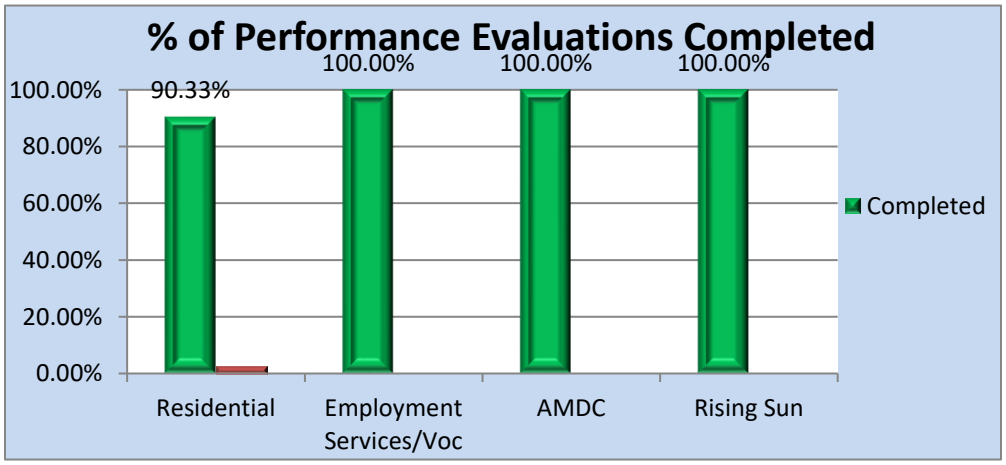


Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, 96% of new hire employees completed all mandated DDA trainings. An audit of the calendar year 2025 training files for newly hired staff members revealed that out of the DDA required training, the total # of staff with pending training is 9. As of December 2025, 9 new hire staff have 90 days to complete their training. The primary difficulty in getting all staff trained within 90 days is that many staff have multiple jobs, and scheduling a several-day training can be difficult. A Training Coordinator is assigned to follow up with staff and ensure all training is on time.



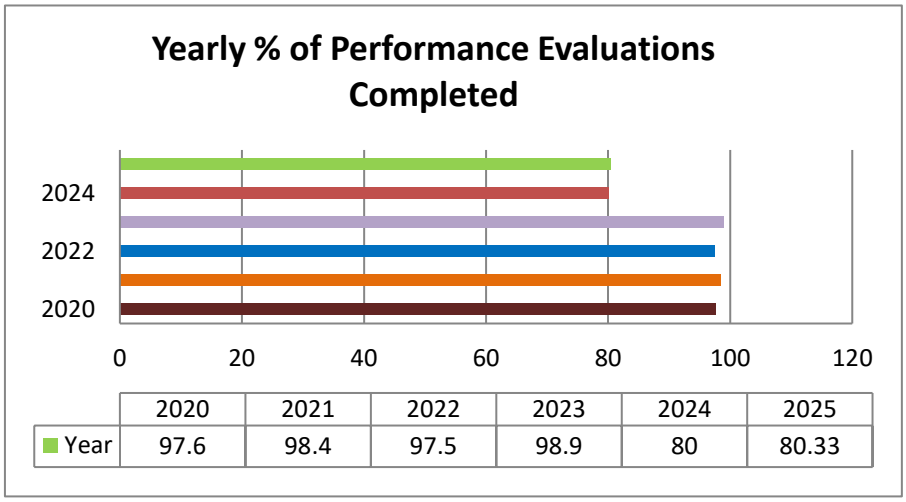
Plan of Action:
Center for Social Chang will continue to use our STEDS online system to monitor the completion rate of new hire training. To make some of these trainings easier to access, CSC changed the format of these trainings into easier-to-consume videos. New hires can get the training information in an easy-to-view and understand format.

Objective #15: Achieve and maintain a completion rate of 97 % performance evaluations completed on time



A monthly audit of employee records is conducted to ensure that annual staff personnel performance evaluations are completed on time. The graph below shows the results of this audit:

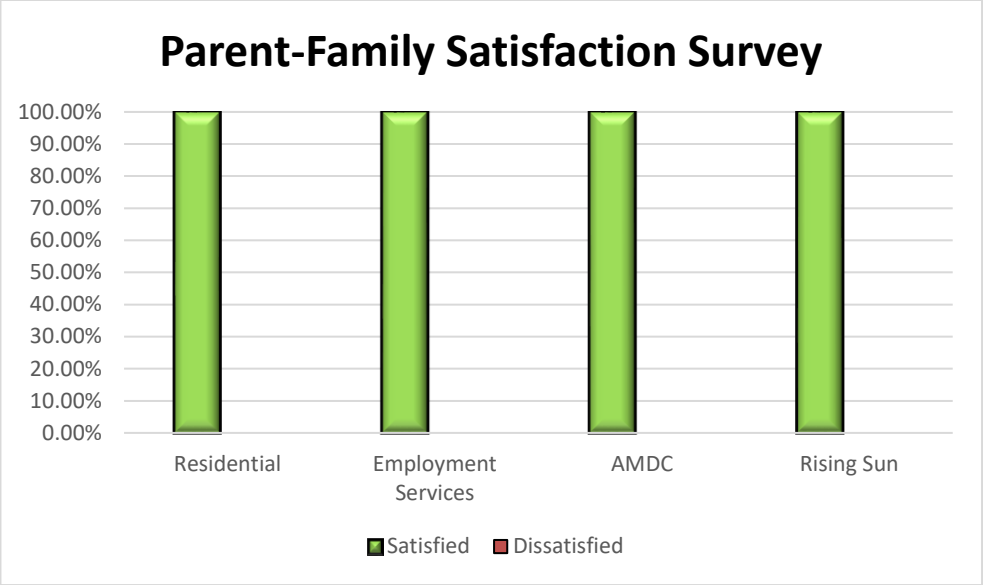
Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, there was an average 97.7% performance evaluation completion rate. 90.33% of performance evaluations were completed for the Residential Program, 100% for the Employment Services/Vocational Program, 100% for the Adult Medical Daycare Program, and 100% for the Rising Sun/Assisted Living Program. Of 635 staff, 292 were new hires, and their evaluation is due next year. It is noted that the staff hire date might be different from their actual work start date. Therefore, 30 + or – days are given for the performance evaluation as the staff completes their training after being hired. At the end of 2024, there were 18 incomplete evaluations.



Plan of Action:
One of the barriers identified is that there is a new team of staff in charge of completing these performance evaluations. They are learning a new process, and they are receiving training to ensure that future performance evaluations are completed. Another barrier was the delay of paperwork coming to the HR office due to changes in employment and role responsibilities. Moving forward, a list of evaluations due will be provided to all supervisors at the beginning of each month during the program meeting. The completion of evaluations will be monitored weekly to ensure timelines are maintained and met. HR staff meets the Program Managers during the Program Meetings.

Objective # 16: Increase family member satisfaction to at least 95%

In 2025, we tracked the level of satisfaction of Individuals served and their family members (parents, legal guardians, siblings, and anyone actively involved in the treatment planning of the individual). It was decided to employ the same survey used in previous years for each group so that a comparison could be made between groups. Family member surveys were distributed at the Annual IP meeting and during the visits with the individuals.



Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, Parent/Family satisfaction was 100%. One appropriate way to look at this data is to determine an "average satisfaction level" among all respondents for all questions. The survey has ten questions to determine the average satisfaction level. We count all positive vs. negative numbers to determine satisfaction level. In 2023 and 2024, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.

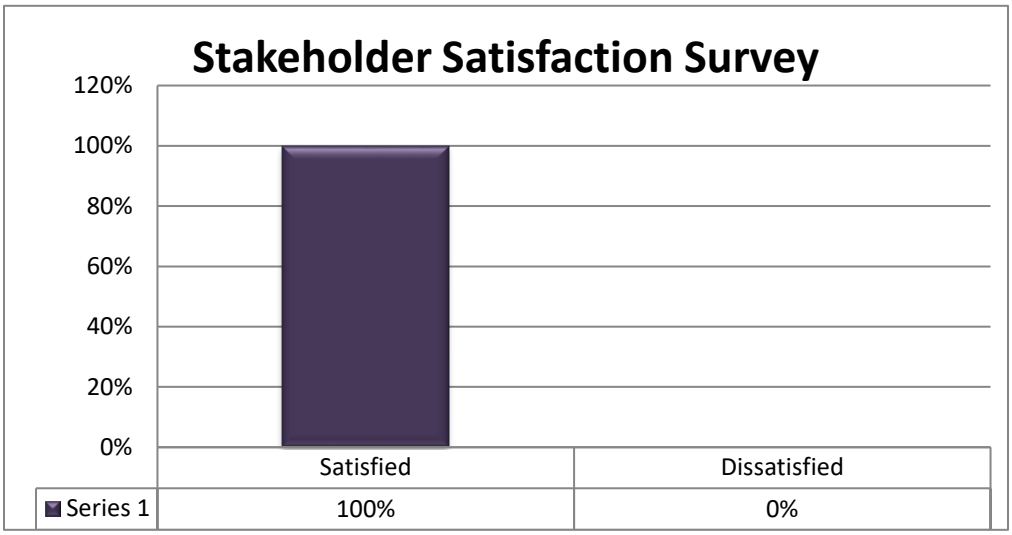
Total # of Families Surveyed	**15**
Total # of Satisfied Responses	150
Total # of Dissatisfied Responses	0

Plan of Action:
Program specialists and Coordinators are responsible for maintaining contact with family members and guardians weekly. It is difficult to increase our sample size due to families not returning the completed survey. We did increase our sample from 8 families in 2024 to 15 families in 2025. We will continue to repeat this survey next year and encourage families to return the survey completed.

Objective #17: Increase Stakeholder satisfaction to at least 99%

In 2025, we tracked the level of satisfaction of community members and stakeholders. It was decided to employ the same survey used in previous years for each group so that a comparison could be made between groups. Surveys to measure stakeholder satisfaction were prepared and disseminated to the

stakeholders in July 2025. We are gathering stakeholder input for Continuous Quality Improvement (CQI). Doing so will enable us to identify areas of satisfaction (or dissatisfaction), allowing us to target these specific areas needing improvement.



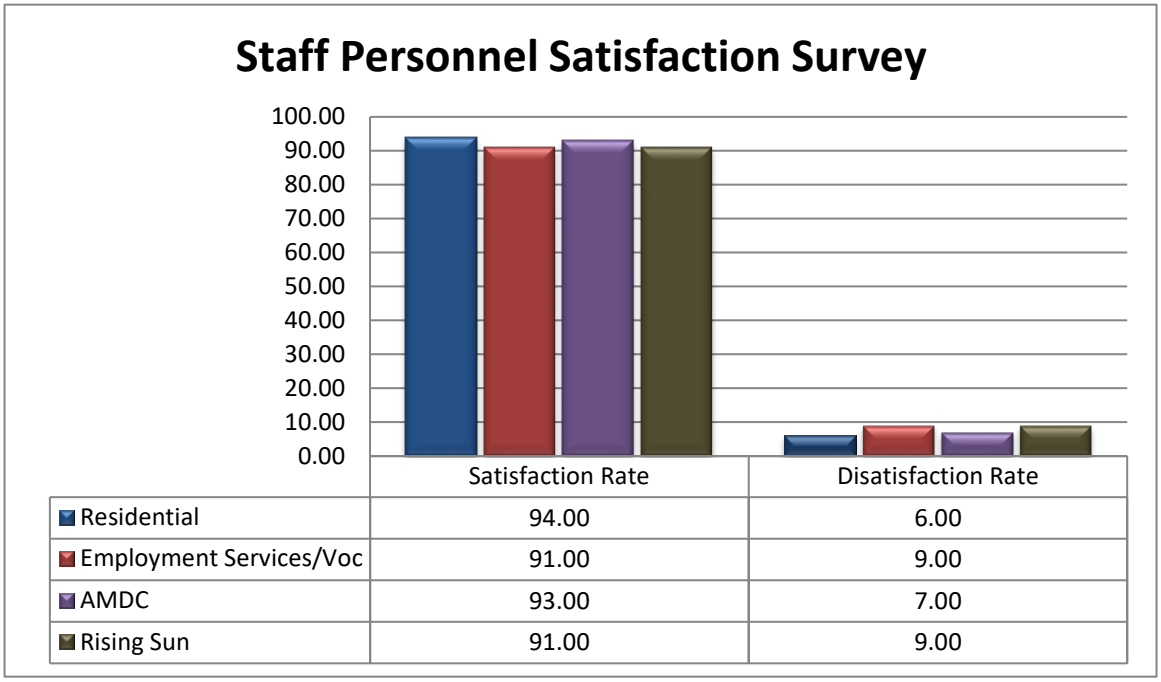
Results/Discussion:
During the reporting period of January 1, 2025, December 31, 2025, stakeholders responded to surveys with 100% satisfaction. One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions. The survey has 10 questions that we use to determine the average satisfaction level. We count all positive vs. negative numbers to determine satisfaction level. In 2023 and 2024, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.

Total # of Stakeholders Survey received	**20**
Total # of Satisfied Responses	200
Total # of Dissatisfied Responses	0

Plan of Action:
The highly positive results indicate that no specific Plan of Action is needed. Therefore, the plan will be to continue the processes already in place. CSC will attempt to reach out to more community members, including stakeholders, neighbors, and member organizations, to gather feedback and to increase the number of responses and feedback.

Objective #18: Increase Staff Personnel satisfaction to at least 90%

Surveys to measure staff personnel satisfaction were prepared and disseminated to the staff personnel in July 2025.



	Satisfaction Rate	Disatisfaction Rate
Residential	94.00	6.00
Employment Services/Voc	91.00	9.00
AMDC	93.00	7.00
Rising Sun	91.00	9.00

Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, staff personnel from all programs responded with 91% satisfaction or higher. In 2024, we had an overall 90.7% satisfaction rate. In 2023, we had an overall 92% satisfaction rate. As an organization, we see a slight increase from 2024. One appropriate way to look at this data is to determine an "average satisfaction level" among all respondents for all questions. The survey has ten questions to determine the average satisfaction level. We count all positive vs. negative numbers to determine satisfaction level.

Total # of Staff Personnel Survey Received	**432**
Total # of Satisfied Responses	4001
Total # of Dissatisfied Responses	319

Plan of Action:
The results looked at all responses, and each program had a satisfaction rate above 91%. All programs had a similar satisfaction rate. The dissatisfied responses result from part-time staff who are not satisfied with the benefits that are provided to them as part-time DSPs. HR will continue to reach out to part-time staff to offer full-time positions before employing outside applicants. This will help provide positions to staff where they have access to all employee benefits.

Objective #19: Increase staff personnel satisfaction survey return rate by at least 10%.

Results/Discussion:

Of the 635 employees in 2025, 432 returned the satisfaction survey. This is 68% of staff. Compared to last year's 58% return rate, we increased the return rate by 10%. We reached our goal to increase the return rate by at least10%. The increased number of staff hired and the longevity of some staff's employment may have led to an increase in return. In 2024, we brought in 11% more staff satisfaction surveys from the year before, so comparatively, we had a similar rate of increase this year.

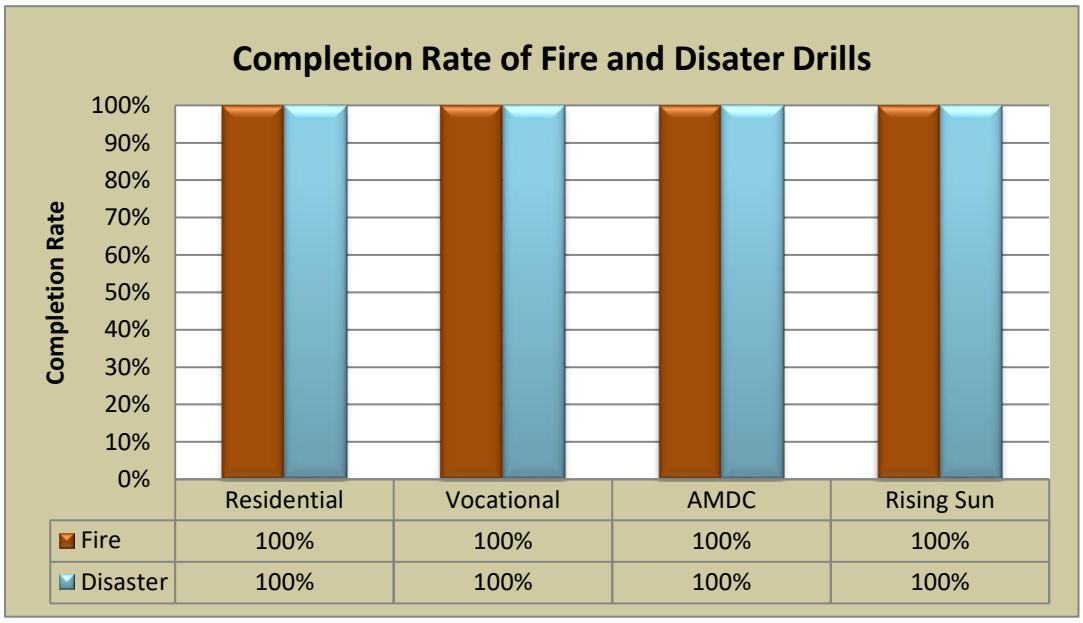
Plan of Action:

We will distribute the staff satisfaction surveys when staff come in for training and all staff meetings to help increase the rate of return.

Objective #20: Maintain at least a 100% rate of compliance to the completion of fire and disaster drills

Results/Discussion:

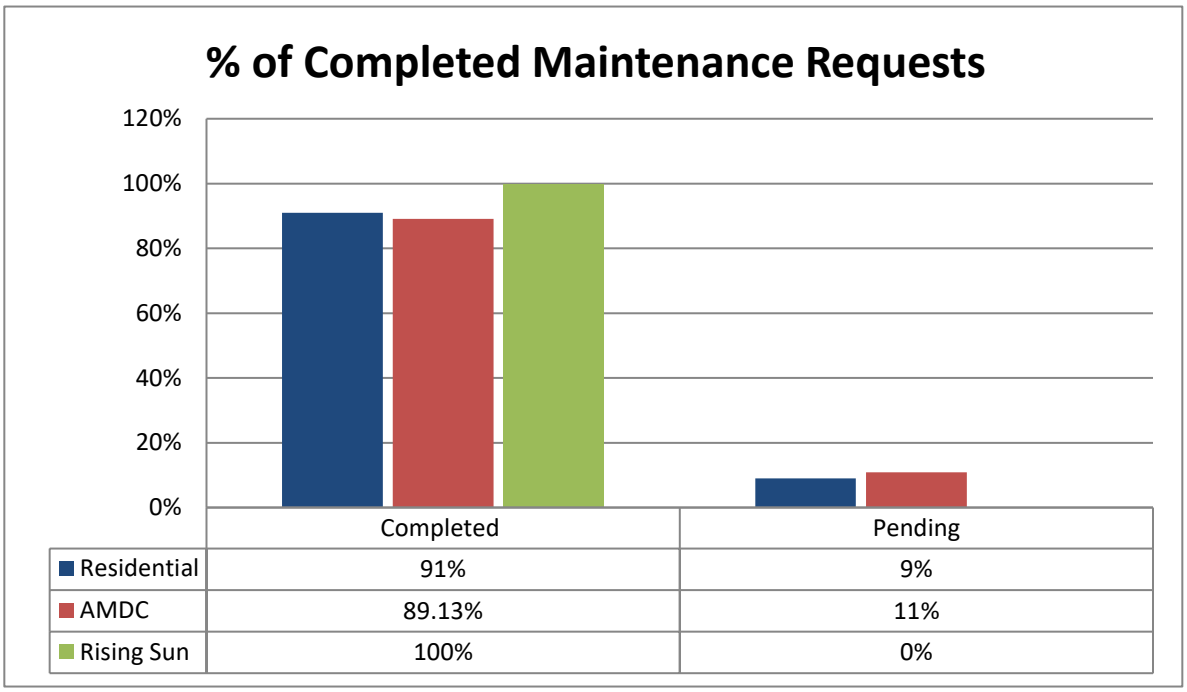
During the reporting period of January 1, 2025, to December 31, 2025, there was a 100% compliance rate for the completion of fire and disaster drills. All fire and disaster drills are completed appropriately as required. CSC has implemented a system to complete a disaster drill (now referred to as an emergency drill) monthly and rotate the shift, as well as utilizing the various emergencies identified in the CSC Emergency Preparedness Plan. Disaster Drills include Bomb Threats, Utility Outages/Evacuation, Violent/Threatening Situations, and Natural Disasters. In 2023 and 2024, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.



Plan of Action:
A schedule of fire drills will continue to be maintained, ensuring each shift completes all drills throughout the year. Disaster drills will continue to occur monthly. The schedule has been modified to include the Bomb Threats, Utility Outage/Evacuation, Violent/Threatening Situation, and Natural Disasters drills for all the shifts. No action plan is needed.

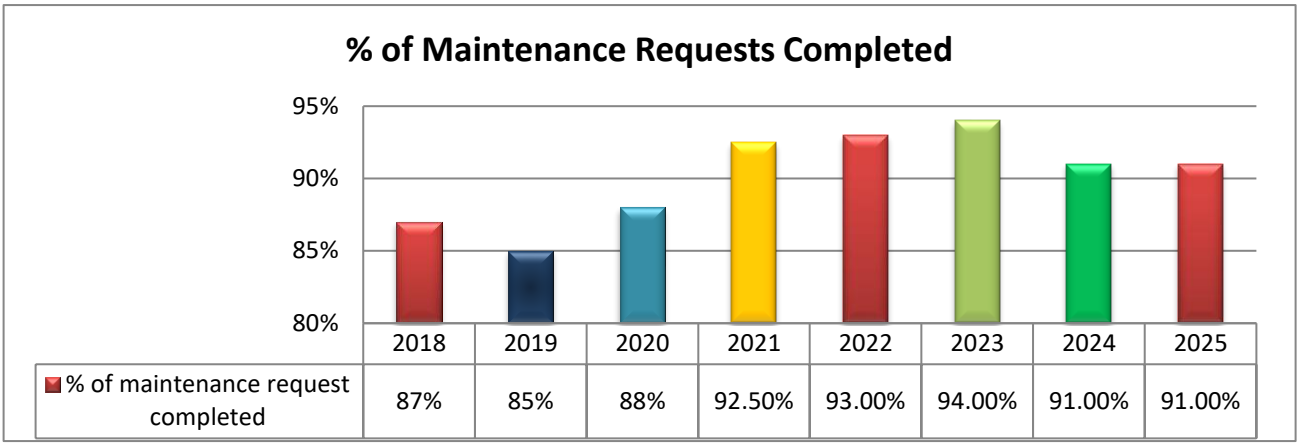
Objective #21: Maintain turnaround of addressing maintenance requests within 24-48 hours with completion rate of 85% during a year.

Center for Social Change currently operates **40** group homes in Randallstown, Windsor Mill, and Laurel/Savage. The maintenance department receives service requests through program managers and direct care staff, who are then assigned to other maintenance staff.



	Completed	Pending
Residential	91%	9%
AMDC	89.13%	11%
Rising Sun	100%	0%

Results/Discussion:
During the reporting period of January 1, 2025, to December 31, 2025, maintenance requests had a turnaround of 24-48 hours with a total completion rate of 91%. Per the maintenance database, the total number of residential requests received in 2025 was 787, and requests completed within 24-48 hours were 716. Some of the requests were delayed as the maintenance team had to order either new parts for certain appliances or order the items directly from the store. One of the barriers for our apartment group home locations is reporting maintenance issues to the leasing office for repairs. This process would take much longer for repairs.



Plan of Action:
Staff and Managers will continue to submit the request to the maintenance department, which will continue to work on it and ensure the database is updated on time. A barrier identified is the lack of maintenance staff to complete the maintenance request. HR is in the process of filling these positions. The graph below shows that the completion rate has increased compared to last year.

Objective #22: Update the Maintenance database with no more than 30 days of entry missing.

Results/Discussion:
During the reporting period of January 1, 2024, to December 31, 2024, the maintenance database was updated with no more than 30 days of missing entries. Per the maintenance database, the total number of requests received in 2025 was 787. It is the responsibility of the Program Manager to enter any noted maintenance request either recommended by a quality assurance home inspection or personal knowledge of any need. Computers in the home and office are equipped to make such entries within one business day. 100% of maintenance requests have been entered into the maintenance database with such time in 2025. In 2023 and 2024, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.

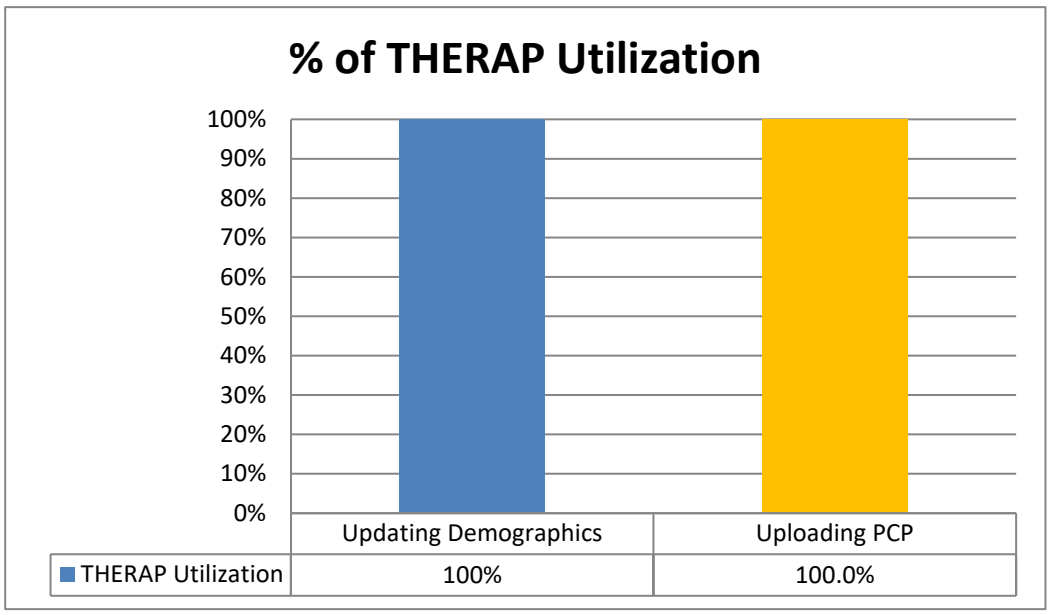
Objective #23 Utilizing STED 100% for all mandated trainings throughout the calendar year 2025

During the reporting period of January 1, 2025 to December 31, 2025, CSC utilized STEDS for 100% of all mandated trainings. STEDS is an in-house software CSC has the flexibility of expanding this system according to CSC's future requirements. All trainings, except for CPR, First Aid, CMT, and MANDT which are in person trainings, are completed by all staff via STEDS. In 2023 and 2024, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.

Plan of Action: Due to the continued unpredictability of global health pandemics, Staff personnel has access to complete the trainings online using STEDS. The goal of utilizing STEDS 100% for all mandated trainings is met.

Objective #24 Utilized THERAP at least 80 % for all people served demographics, IP, and outcomes

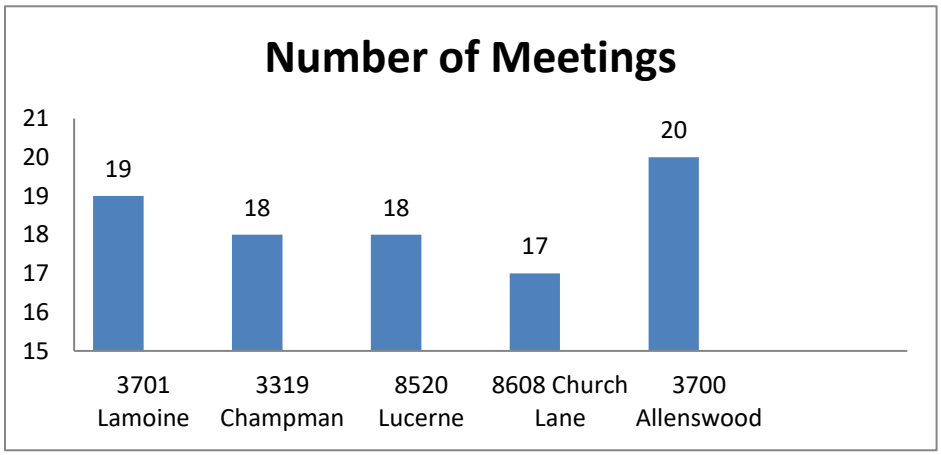
During the reporting period of January 1, 2025, to December 31, 2025, THERAP was used 100% of the time for uploading demographic information and 100% for uploading PCP information. The objective of using Therap was met. Currently, the staff is capturing the data for demographics on the system, IP/BP, and progress. Behavioral incidents are documented on THERAP, and reports can be generated as needed. Quality assurance staff also uses and updates the demographics and can pull reports directly from THERAP. The goal was met for uploading PCP on THERAP. In 2024 and 2023, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.



Plan of Action:
We met all of our Therap Utilization goals in 2025, therefore no plan of action is needed.

Objective #25 Utilizing STEDS 85% for ALU meeting minutes

STEDS, the online documentation section (Friday Packet) of the system, has house Meeting Notes to report each week's house meeting notes to the Program Team. These meeting minutes are used to identify activities and any concerns of the person served. A sample audit was completed for 5 ALUs to check for the completion of ALU meeting minutes. The audit was completed for January, March, July, and October. The minimum number of meetings required for each ALU was 16. All homes sampled had either 17 or more meeting notes in STEDS. Following are the numbers each ALU achieved. In 2024 and 2023, our compliance rate for this goal was 100%. We are remaining consistent with our compliance rate in 2025 as well.



Plan of Action:
During the reporting period of January 1, 2025, to December 31, 2025, STEDS was used 100% of the time for all ALU meeting minutes. Staff personnel have access to completed sample ALU meeting minutes for their homes. It is noted that a few homes are still using paper forms for the individuals who have funds or activity requests, as a signature is required for these items. No action plan is needed.

APPENDICES

Appendix A - Resources Used for Data Collection and Analysis

Analysis of Medical/Nursing Services

Therap Online Documentation which contains all information regarding:

- Medical appointments (PCP and specialty)
- Annual physical examinations
- Laboratory workups done
- Hospital/ER visits
- Nutritional evaluations
- Initial nursing assessments
- Nursing Plan of Care
- 45 Day Reviews
- Interim nursing visits (in follow-up to hospital visits)
- The scheduled date for all medical appointments (day/time)
- Whether or not the appointment was successfully kept
- If not kept, reasons why appointments were not kept
- Staff member responsible for ensuring the appointment is kept

Medication Administration Books which contain:

- Current MARs
- Current PMOFs
- Various log sheets (e.g. - blood pressure logs, blood sugar logs, weight logs, seizure logs, etc.)
- Nursing Plan of Care

Analysis of Individual Plans

- Individual Plan/Behavior Plan Database- contains information regarding:
- Start date for IP/BP and for each individual
- Expiration date for IP/BP for each individual
- Required meeting sign-in sheets
- Required individual permission/consent forms
- Copies of IP's and BP's, including goals and Progress Notes
- Implementation dates for IPs

Analysis of staff training

HR Database- contains information regarding:

- Start date for all individual staff
- Documentation of all required personnel information
- Documentation of all required trainings
- Evaluation due date

Training Database- contains information regarding:

- Schedule for all required pending training for all individual staff
- Documentation of completion of all required trainings for all individual staff
- Expiration dates for all required trainings, certification, etc. for all individual staff

Analysis of Incident Reporting:

Incident Reporting Database- containing information regarding:

- Type of incident
- Place of incident
- Date of incident
- Staff involved
- Nature of incident
- Status of A-5/A-7 reporting
- Investigator
- A5 and A7 reports

Analysis of Stakeholder, family, employee Satisfaction:

- Stakeholder Survey
- Parent/Family member Survey
- Employee Survey

Appendix B - Members of Standing Committee

Members of the Standing Committee at CSC are:

Review of BPs

Licensee Staff:

- Dana Dimas, Chief of Programs - Chair
  (dana@centerforsocialchange.org)
  6600 Amberton Drive, Elkridge, MD 21075
  410-579-6789

- Thomas Alexander, Operations Manager
  (thomas@centerforsocialchange.org)
  6600 Amberton Drive, Elkridge, MD 21075
  410-579-6789

Community members:

- Remy Ceraulo remy.ceraulo@gmail.com

- Greg DeVore gregdevore@gmail.com

Review of reportable incidents:
Licensee staff:

- Simrat Ceraulo
  Assistant Director of Programs, CSC (simrat@centerforchange.org)

- Thomas Alexander
  Operations Manager, CSC (thomas@centerforsocialchange.org)

Community members:

- Remy Ceraulo remy.ceraulo@gmail.com

- Greg DeVore gregdevore@gmail.com

Alternate member: Sajid Tarar.

The Standing Committee meets at least quarterly**.** During the 2025 calendar year, the Standing Committee met on January 4, 2025; April 4 2025; July 7, 2025; October 8, 2025.

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