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| **Provider Address:** |

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| 33 Perry Avenue , Attleboro |

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| **Name of PersonCompleting Form:** |

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| Penny Potter |

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| **Date(s) of Review:** |

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| 01-DEC-19 to 21-FEB-20 |

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| **Follow-up Scope and results :** |  |  |
| Service Grouping | Licensure level and duration |  # Indicators std. met/ std. rated  |
| Residential and Individual Home Supports | 2 Year License | 6/6 |
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| Employment and Day Supports | 2 Year License | 3/3 |
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| **Summary of Ratings** |

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| **Administrative Areas Needing Improvement on Standard not met - Identified by DDS** |
| **Indicator #** | L48 |
| **Indicator** | HRC |
| **Area Need Improvement** | The member with clinical expertise on the Central Human Rights Committee (HRC) did not attend any meetings in person or through an electronic method. Additionally, this member is the chairperson and the HRC bylaws state that the chairperson "shall preside at all meetings of the Committee." The agency needs to ensure it has an effective Human Rights Committee. |
| **Process Utilized to correct and review indicator** | The Chairperson for the Committee was also the clinical expertise member for the Committee. The Clinical Department had already identified the issues prior to our licensing review and had already started to resolve it. The HRC meeting on December 19, 2019 was the first meeting with the new Committee configuration. Mr. Darren Marino was voted in as the new Chairperson and James Peters, a BCBA, attended as well and will now be the clinical expertise for the Committee. The By-laws were updated and approved to now reflect that the "chairperson or their designee shall preside at all meetings of the Committee". We will continue to monitor Committee Membership and Committee Meetings to ensure they remain an effective and compliant Human Rights Committee. |
| **Status at follow-up** | All issues resolved. Continue to monitor to ensure full compliance. |
| **Rating** | Met |
| **Indicator #** | L65 |
| **Indicator** | Restraint report submit |
| **Area Need Improvement** | Twenty-seven restraint reports were not submitted within required timelines. The agency needs to ensure restraint reports are submitted within required timelines. |
| **Process Utilized to correct and review indicator** | Review policies and procedures and retrain administrative staff on adhering to the regulatory time frames. The issue seemed to be more with finalizing the reports within the allotted time and this issue was reviewed with the Program Directors who have the finalizing responsibility. Quality Assurance will audit HCSIS monthly to ensure compliance in this area. Further training and/or discipline will occur if issues continue. |
| **Status at follow-up** | Although significant progress was made in submitting reports in a timely manner, it was not 100% which leaves room for additional improvement. This is an on-going supervision issue for administrators to ensure compliance. |
| **Rating** | Met |
| **Employment and Day Supports Areas Needing Improvement on Standard not met - Identified by DDS** |
| **Indicator #** | L91 |
| **Indicator** | Incident management |
| **Area Need Improvement** | Five out of thirty-three incidents were not submitted and/or finalized within the required time frames. The agency needs to ensure that all incidents are submitted and finalized within the required timelines. |
| **Process Utilized to correct and review indicator** | Staff were retrained on regulatory timelines. We are making every effort to ensure compliance. We require program directors to list HCSIS completion number so administrators can follow up to ensure compliance. In addition, success in a managerial scorecard will now affect Annual Performance Appraisals and monetary compensation for success in completing the job responsibilities. This was another way to detail the importance of compliance in this area and to motivate managerial staff to ensure timelines are strictly followed. |
| **Status at follow-up** | The Senior Program Director for CBDS has ensured compliance with 100% accuracy. |
| **Rating** | Met |
| **Residential and Individual Home Supports Areas Needing Improvement on Standard not met - Identified by DDS** |
| **Indicator #** | L29 |
| **Indicator** | Rubbish/combustibles |
| **Area Need Improvement** | At three out of ten homes, combustibles were stored near heating equipment. The agency needs to ensure that no rubbish or other combustibles are accumulated near heating equipment and exits. |
| **Process Utilized to correct and review indicator** | All residences were inspected to ensure this was not an issue with the remaining sites. This area of need was added to the Safety Checklist to ensure compliance with all residential Program Coordinators and/or Program Directors. All staff were retrained to ensure compliance. Safety checklists are reviewed at least monthly at the Health and Safety Meeting that includes administrative staff, direct support staff and individuals. |
| **Status at follow-up** | All sites remain compliant. Spot checks on Safety Checklists are conducted to ensure the data on compliance is accurate. Staff will be re-trained if there are any issues with compliance in this area. |
| **Rating** | Met |
| **Indicator #** | L61 |
| **Indicator** | Health protection in ISP |
| **Area Need Improvement** | Three individuals used support and health related protections. A process for documenting safety was not in place for two individuals The agency needs to ensure staff conduct and document safety checks of support and health related protections |
| **Process Utilized to correct and review indicator** | A form was added to the electronic platform that will require each shift to complete the safety checklist for all support and health related protections at their assigned homes. The Clinical Department will ensure that any changes in support and health related protections will be updated in the electronic checklist. All staff were re-trained in this area and audits will be conducted to ensure compliance. Any compliance issue will be reviewed at the monthly Health and Safety Meetings and action plans will be developed if compliance remains an issue. Electronic forms are completed in real time with sign offs from staff who were assigned to document the safety check. QA and the Clinical Department will conduct random audits to ensure full compliance as well. |
| **Status at follow-up** | All individualized information was downloaded to the electronic platform and all staff were trained on this area of need. |
| **Rating** | Met |
| **Indicator #** | L64 |
| **Indicator** | Med. treatment plan rev. |
| **Area Need Improvement** | Two out of nine Medication Treatment Plans (MTP) were not reviewed by the required groups. |
| **Process Utilized to correct and review indicator** | The ISP completion checklist for the agency was updated to ensure that all MTP's are reviewed at the ISP meeting. Staff involved in the ISP process will ensure that the Service Coordinator is clear on the MTP and understands the importance of the information and documentation is part of the completed ISP document. As a precaution, when the completed ISP returns to Amego for signature, the content will be reviewed to ensure that all MTP information is included in the document. If it is missing, the document will be returned to the Service Coordinator for corrections and will only be signed once the information is added. |
| **Status at follow-up** | Staff have been retrained to ensure compliance. MTP's have been included in all ISP's. |
| **Rating** | Met |
| **Indicator #** | L91 |
| **Indicator** | Incident management |
| **Area Need Improvement** | At three locations incident reports were not submitted and/or finalized within the required time frames. The agency needs to ensure that all incidents are submitted and finalized within the required timelines. |
| **Process Utilized to correct and review indicator** | Alerts have been created for notification of when incident reports have been completed. QA staff have been assigned to clusters to review the alerts daily and monitor timelines. QA staff will provide additional notification to responsible parties of impending timelines. Incident reports already flow through a review process, the review process will also include timeline adherence review in the Health and Safety Committee. |
| **Status at follow-up** | Staff have been retrained on incident timelines. QA staff have been monitoring HCSIS incident timelines and communicating with responsible parties on incidents nearing due dates. |
| **Rating** | Met |

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