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| Provider | ARC OF BRISTOL COUNTY |  | Provider Address | 141 Park St., Attleboro |
| Survey Team |  Marchese,Michael; Condon,Kayla; Gregory,Katherine;  |  | Date(s) of Review | 14-APR-21 to 20-APR-21 |

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| **Mid-Cycle Scope and results :**  |
| Service Grouping | Licensure level and duration |  # Indicators std. met/ std. rated at Mid-Cycle | Sanction status prior to Mid-Cycle | Combined Results post- Mid-Cycle;  | Sanction status post Mid-Cycle |
| Residential and Individual Home Supports | Defer Licensure | 24/30 | o | Eligible for new business | 2 Year License with Mid-Cycle Review75/85 (88.24% ) | x | Eligible for New Business(80% or more std. met; no critical std. not met) |
| 7 Locations 9 Audits  |  |  | x | Ineligible for new business.  |  | o | Ineligible for New Business(<=80% std met and/or more critical std. not met) |

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| **Summary of Ratings** |

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| **Residential and Individual Home Supports Areas Needing Improvement on Standards not met:** |
| **Indicator #** | L5 |
| **Indicator** | Safety Plan |
| **Area Need Improvement** | At two homes the safety plans did not list all members of the household that may require assistance evacuating. At one location only half of the staff were knowledgeable in the implementation strategies outlined in the safety plan. The agency needs to ensure that all safety plans have all required components and all staff are trained. |
| **Status at mid-cycle** |  Safety plans at all seven homes were current and included all required components, and all staff were trained. |
| **#met /# rated at mid-cycle** |  7/7 |
| **Rating** | MET |
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| **Indicator #** | L7 |
| **Indicator** | Fire Drills |
| **Area Need Improvement** | At one of two homes, staff were not conducting fire drills with the required minimum staff ratio. The agency needs to ensure that fire drills are being conducted as outline in the safety plan. |
| **Status at mid-cycle** |  Fire drills at one home were conducted as required and as outlined in the safety plan. |
| **#met /# rated at mid-cycle** |  1/1 |
| **Rating** | MET |
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| **Indicator #** | L8 |
| **Indicator** | Emergency Fact Sheets |
| **Area Need Improvement** | Four out of the eleven emergency fact sheets did not contain accurate information, including a diagnoses and guardianship status. The agency needs to ensure emergency fact sheets are up to date with accurate information. |
| **Status at mid-cycle** |  Eight of nine emergency fact sheets were current and accurate. One emergency fact sheet did not contain all required information, including a descriptive characteristics and other information of use in finding an individual if missing. The agency needs to ensure emergency fact sheets are up to date with accurate information. |
| **#met /# rated at mid-cycle** |  8/9 |
| **Rating** | MET |
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| **Indicator #** | L10 |
| **Indicator** | Reduce risk interventions |
| **Area Need Improvement** | For two of four individuals, interventions to reduce risk were not being implemented. One individual utilizes equipment to reduce the likelihood of falls. Staff were not aware of where this equipment was or how to use it. Another individual was being left in the community, despite requiring supervision. The agency needs to ensure that staff are knowledgeable on how to support the individuals who are at risk and implement required staffing patterns and interventions designed to mitigate risk. |
| **Status at mid-cycle** |  For one individual, staff were knowledgeable of his risk behaviors, strategies were in place and interventions were being implemented to reduce risk. |
| **#met /# rated at mid-cycle** |  1/1 |
| **Rating** | MET |
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| **Indicator #** | L12 |
| **Indicator** | Smoke detectors |
| **Area Need Improvement** | Two of the six homes did not have smoke and carbon monoxide detectors located where required or were not operational. The agency needs to ensure smoke and carbon monoxide and smoke detectors are located where required and are operational. |
| **Status at mid-cycle** |  Five of six homes had operational smoke and carbon monoxide detectors located were required. At one location, the carbon monoxide detector was not within 10 feet of the bedroom. |
| **#met /# rated at mid-cycle** |  5/6 |
| **Rating** | MET |
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| **Indicator #** | L13 |
| **Indicator** | Clean location |
| **Area Need Improvement** | Two of six locations were not clean and/or free of insect infestation. The agency needs to ensure all locations are clean and/or free of an infestation. |
| **Status at mid-cycle** |  Six homes visited were observed to be clean and free of rodent and/or insect infestation. |
| **#met /# rated at mid-cycle** |  6/6 |
| **Rating** | MET |
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| **Indicator #** | L15 |
| **Indicator** | Hot water |
| **Area Need Improvement** | At three of the six homes water temperatures did not test within the required range. The agency needs to ensure water temperatures test between 110 and 120 degrees. |
| **Status at mid-cycle** |  At six homes visited, hot water temperatures tested within the required range of between 110 and 120 degrees. |
| **#met /# rated at mid-cycle** |  6/6 |
| **Rating** | MET |
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| **Indicator #** | L17 |
| **Indicator** | Egress at grade  |
| **Area Need Improvement** | Two out of six homes had a second means of egress on the ground floor that individuals were not able to use. The agency needs to ensure that at each home, egresses at grade can be easily opened by individuals without the use of a key. |
| **Status at mid-cycle** |  One home had two useable means of egress from floors at grade level. |
| **#met /# rated at mid-cycle** |  1/1 |
| **Rating** | MET |
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| **Indicator #** | L23 |
| **Indicator** | Egress door locks |
| **Area Need Improvement** | One home had locks on two bedroom doors that provided means of egress. The agency needs to ensure that no bedrooms providing egress have locks. |
| **Status at mid-cycle** |  At one home visited, bedrooms providing assess to an egress did not have locks on the doors. |
| **#met /# rated at mid-cycle** |  1/1 |
| **Rating** | MET |
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| **Indicator #** | L24 |
| **Indicator** | Locked door access |
| **Area Need Improvement** | At one of two homes the keys to bedroom doors were not carried by staff and/or could not be easily found. The agency needs to ensure that keys to bedroom doors are quickly accessible by staff and all staff are aware of their location for emergency purposes. |
| **Status at mid-cycle** |  At one home visited, all bedrooms not providing access to an egress had locks on doors that could be opened by individuals from the inside, and keys were easily accessible by staff. |
| **#met /# rated at mid-cycle** |  1/1 |
| **Rating** | MET |
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| **Indicator #** | L27 |
| **Indicator** | Pools, hot tubs, etc. |
| **Area Need Improvement** | In two homes with swimming pools, individuals had not been assessed for their water safety skills. The agency needs to assess individuals for their skills related to water safety and determine the level of support they each need. The agency needs to ensure that staff and care providers provide the level of support each individual's needs based on the completed assessment. |
| **Status at mid-cycle** |  Two individuals living in homes with pools had been assessed for their water safety skills, including the level of supports needed for the safe use of their pool. |
| **#met /# rated at mid-cycle** |  2/2 |
| **Rating** | MET |
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| **Indicator #** | L35 |
| **Indicator** | Preventive screenings |
| **Area Need Improvement** | Three out of eleven individuals had not received preventative medical screenings such as a colonoscopy, or other recommended health screenings based on their age, history or medical conditions. The agency needs to ensure individuals receive routine preventative screenings. |
| **Status at mid-cycle** |  Seven individuals had received required medical preventative screenings. Two individuals had not received preventative medical screenings and/or immunizations, including bone density testing and Tetanus booster shot. The agency needs to ensure individuals receive routine preventative screenings. |
| **#met /# rated at mid-cycle** |  7/9 |
| **Rating** | NOT MET |
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| **Indicator #** | L36 |
| **Indicator** | Recommended tests |
| **Area Need Improvement** | Three out of eleven individuals had not received recommended tests or appointments with specialists. The agency needs to ensure recommended tests and appointments with specialists occur. |
| **Status at mid-cycle** |  Five individuals had received recommended tests and follow. For four individuals requiring ongoing healthcare management, follow-up consultation with specialists had not occurred, including guidance on glucose level testing, vital sign testing and parameters for a fluid intake restriction. The agency needs to ensure recommended tests and appointments with specialists occur. |
| **#met /# rated at mid-cycle** |  5/9 |
| **Rating** | NOT MET |
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| **Indicator #** | L38 |
| **Indicator** | Physician's orders |
| **Area Need Improvement** | Four out of nine individuals with significant diagnosis requiring ongoing management by a health care professional did not have treatment protocols in place. Two out of nine individuals had treatment protocols which lacked required components such as signs and symptoms specific to that individual or instructions on use and cleaning of medically necessary equipment. The agency needs to ensure that individuals with significant medical conditions that require ongoing management have medical / health care treatment protocols in place with all required components. |
| **Status at mid-cycle** |  Six individuals with significant medical diagnoses requiring management by a health care professional had treatment protocols in place that staff/providers were knowledgeable and that they were being consistently followed. For one individual, the healthcare management plan lacked directions for what to do in the event the individual exhibited symptoms of his identified medical diagnosis. |
| **#met /# rated at mid-cycle** |  6/7 |
| **Rating** | MET |
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| **Indicator #** | L43 |
| **Indicator** | Health Care Record |
| **Area Need Improvement** | Health care records for six of eleven people were not accurate. The health care records reviewed were missing diagnoses, dietary needs, allergies, and health related protections. The agency needs to ensure that health care records are accurate and maintained. |
| **Status at mid-cycle** |  All nine health care records reviewed were accurate and updated as required. |
| **#met /# rated at mid-cycle** |  9/9 |
| **Rating** | MET |
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| **Indicator #** | L46 |
| **Indicator** | Med. Administration |
| **Area Need Improvement** | Of ten individuals, medications were not properly administered for four. For several, medications orders were either expired or not present. Additionally, orders were not always clear which lead to confusion regarding which medications to give. The agency needs to ensure that all medications are administered accurately. |
| **Status at mid-cycle** |  For seven individuals reviewed, all prescription medications were being administered according to the written orders and were properly documented. |
| **#met /# rated at mid-cycle** |  7/7 |
| **Rating** | MET |
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| **Indicator #** | L47 |
| **Indicator** | Self medication |
| **Area Need Improvement** | One individual who administers his medication did not meet the criteria to be self-medicating based on his assessment. The agency needs to ensure individuals are provided the necessary support to safely administer medication. |
| **Status at mid-cycle** |  Two individuals who self-administer their medications had been assessed of their skills in this area and a plan of support was in place if found unable to remain independent. |
| **#met /# rated at mid-cycle** |  2/2 |
| **Rating** | MET |
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| **Indicator #** | L56 |
| **Indicator** | Restrictive practices |
| **Area Need Improvement** | A restrictive practice was being implemented for one individual without a plan to fade or eliminate the practice. This plan had not been reviewed by the Human Rights Committee. The agency needs to ensure that restrictive practices include all required components and undergo all required reviews. |
| **Status at mid-cycle** |  For one individual's restrictive practice there was no plan to fade the restriction and the restrictive practice was not included in the ISP. The agency needs to ensure that restrictive practices include all required components and undergo all required reviews. |
| **#met /# rated at mid-cycle** |  0/1 |
| **Rating** | NOT MET |
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| **Indicator #** | L57 |
| **Indicator** | Written behavior plans |
| **Area Need Improvement** | For two individuals at one location, the house practice of implementing a 9pm "bed time" and utilizing time-out for swearing was being utilized. There was no written plan to rationalize the need for these restrictions for either person. The agency needs to ensure that all practices that limit an individual's rights are only developed and implemented in accordance with individuals' needs and then are outlined within a written plan. |
| **Status at mid-cycle** |  This indicator was not rated during this mid-cycle review as these supports were not in place for anyone visited. |
| **#met /# rated at mid-cycle** |   |
| **Rating** | NOT RATED |
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| **Indicator #** | L58 |
| **Indicator** | Behavior plan component |
| **Area Need Improvement** | For two individuals the practice of implementing a 9pm "bed time" and utilizing time-out for swearing was being utilized. Neither individual had a written plan identifying behaviors for modification, and the rationale for t these restrictions as the least restrictive for the person. The agency needs to ensure that all practices that limit an individual's rights are originated from an individualized need, are in a written form and contain data, justification as the least restrictive and plans to fade when behavioral shaping has occurred. |
| **Status at mid-cycle** |  This indicator was not rated during this mid-cycle review as these supports were not in place for anyone visited. |
| **#met /# rated at mid-cycle** |   |
| **Rating** | NOT RATED |
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| **Indicator #** | L59 |
| **Indicator** | Behavior plan review |
| **Area Need Improvement** | For two individuals the systemic practice of implementing a 9pm "bed time" and utilizing time-out for swearing was being utilized. The agency needs to ensure that all practices that limit an individual's rights are referred to the HRC for their review and approval. |
| **Status at mid-cycle** |  This indicator was not rated during this mid-cycle review as these supports were not in place for anyone visited. |
| **#met /# rated at mid-cycle** |   |
| **Rating** | NOT RATED |
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| **Indicator #** | L61 |
| **Indicator** | Health protection in ISP |
| **Area Need Improvement** | For two out of five individuals with supportive devices, the plan in place did not contain what type or the frequency of safety checks. The agency needs to ensure that for all supports and health related protections all the required components are in place. |
| **Status at mid-cycle** |  Supports and/or health related protections for four individuals were included in their ISPs including the continued need for the support and/or health protection. For one individual, staff had not been trained on two supportive devices. |
| **#met /# rated at mid-cycle** |  4/5 |
| **Rating** | MET |
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| **Indicator #** | L63 |
| **Indicator** | Med. treatment plan form |
| **Area Need Improvement** | For five of seven individuals reviewed medication treatment plans (MTP) were not written with all the required components. Two plans were not in place, one plan did not have all medications listed, and for two plans data was not being tracked at outline in the MTP. The agency needs to ensure that MTPs are present, list all medications, and that data is being tracked and shared with the prescribing physician. |
| **Status at mid-cycle** |  For six individuals supported with behavior modifying medication, medication treatment plans with all the required components were in place and implemented. Three of nine medication treatment plans (MTP) did not contain all required components, including a missing medication, a description of the behaviors to be modified, and a plan to reduce or eliminate the need for medication. The agency needs to ensure that MTPs are present, list all medications, and that data is being tracked and shared with the prescribing physician. |
| **#met /# rated at mid-cycle** |  6/9 |
| **Rating** | NOT MET |
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| **Indicator #** | L64 |
| **Indicator** | Med. treatment plan rev. |
| **Area Need Improvement** | The medication treatment plans for 5 out of 6 individuals had not received the required reviews. The agency needs to ensure that all medication treatment plans receive review through the ISP process. |
| **Status at mid-cycle** |  Eight of nine medication treatment plans had been reviewed by the individuals' ISP teams. One medication treatment plan (MTP) reviewed did not contain all of the individual's behavior modifying medications. The agency needs to ensure that all MTPs receive review through the ISP process. |
| **#met /# rated at mid-cycle** |  8/9 |
| **Rating** | MET |
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| **Indicator #** | L67 |
| **Indicator** | Money mgmt. plan |
| **Area Need Improvement** | Six out of nine individuals who receive support with managing their funds, did not have a written money management plan or the plan did not outline the level of support the individual needed or was provided. The agency needs to ensure all individuals have a written money management plan with all required components when the agency has shared or delegated money management responsibility. |
| **Status at mid-cycle** |  All nine individuals reviewed had money management support plans in place that included strategies to reduce or eliminate staff assistance, and agreement was present as required. |
| **#met /# rated at mid-cycle** |  9/9 |
| **Rating** | MET |
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| **Indicator #** | L68 |
| **Indicator** | Funds expenditure |
| **Area Need Improvement** | Two of the nine individuals had expenditures that did not directly benefit the individual. The agency needs to ensure all expenditures of funds are made for purposes that directly benefit the individual. |
| **Status at mid-cycle** |  For eight of nine individuals, expenditures of their funds were made only for the purposes directly benefitting them. For one individual, there was no agreement in place describing the allocation of payment for a shared cell phone plan. |
| **#met /# rated at mid-cycle** |  8/9 |
| **Rating** | MET |
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| **Indicator #** | L69 |
| **Indicator** | Expenditure tracking |
| **Area Need Improvement** | Expenditures were reviewed for nine individuals. For two individuals, required receipts for purchases were missing, and there was a lack of a financial expenditure tracking. The agency needs to ensure individuals' expenditures are documented and tracked accurately, and that receipts are maintained in accordance with agency's financial policies. |
| **Status at mid-cycle** |  For six individuals adequate tracking of expenditures was in place. For three individuals, money was not being tracked accurately, including gift cards not accounted for, inadequate receipts, and assets exceeding allowable limits. The agency needs to ensure individuals' expenditures are documented and tracked accurately, and that receipts are maintained in accordance with agency's financial policies. |
| **#met /# rated at mid-cycle** |  6/9 |
| **Rating** | NOT MET |
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| **Indicator #** | L70 |
| **Indicator** | Charges for care calc. |
| **Area Need Improvement** | Charges for Care were reviewed for 10 individuals. For two individuals, the agency did not provide an explanation of how their charges for care were calculated. Another individual did not have an explanation for the calculation of additional charges added to their charges for care. The agency needs to provide individuals and rep payees an explanation of how charges for care are calculated. |
| **Status at mid-cycle** |  For four individuals the charges for care were accurately calculated. For three of seven individuals, charges for care were not calculated appropriately, including lack of adequate notice for increases in charges and an incorrect calculation. The agency needs to provide individuals and rep payees an explanation of how charges for care are calculated. |
| **#met /# rated at mid-cycle** |  4/7 |
| **Rating** | NOT MET |
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| **Indicator #** | L78 |
| **Indicator** | Restrictive Int. Training |
| **Area Need Improvement** | For one of two restrictive practices reviewed, staff had not been trained proper use of a device. For all restrictive interventions the agency needs to ensure comprehensive training is provided to ensure effective implementation of restrictive practices. |
| **Status at mid-cycle** |  This indicator was not rated during this mid-cycle review as these supports were not in place for anyone visited. |
| **#met /# rated at mid-cycle** |   |
| **Rating** | NOT RATED |
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| **Indicator #** | L85 |
| **Indicator** | Supervision  |
| **Area Need Improvement** | In two out of seven homes, adequate supervision from management was not being provided as evidenced by systemic issues identified regarding health care coordination/oversight, medication monitoring, safe evacuation, and long-standing environmental concerns. The agency needs to provide regular supervision and oversight to ensure that individuals have optimal living conditions, and staff are provided with training and tools to ensure the health and safety of individuals in their care. |
| **Status at mid-cycle** |  At all seven locations, processes for the provision of supervision, oversight and staff/provider development were in place. |
| **#met /# rated at mid-cycle** |  7/7 |
| **Rating** | MET |
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| **Indicator #** | L86 |
| **Indicator** | Required assessments |
| **Area Need Improvement** | For two individuals, ISP assessments were not submitted within the required timelines. The agency needs to ensure that all assessments are submitted in preparation for the ISP 15 days in advance of the scheduled ISP Meeting. |
| **Status at mid-cycle** |  For six individuals, ISP assessments had been submitted within the required timeline. For three individuals, ISP assessments were not submitted within the required timeline. However, in two instances the agency had not been provided with sufficient notice of the two ISP meeting dates. The agency needs to ensure that all assessments are submitted in preparation for the ISP 15 days in advance of the scheduled ISP meeting. |
| **#met /# rated at mid-cycle** |  6/7 |
| **Rating** | MET |
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| **Indicator #** | L87 |
| **Indicator** | Support strategies |
| **Area Need Improvement** | For three individuals reviewed, ISP assessments were not submitted within the required timelines. The agency needs to ensure that all assessments are submitted in preparation for the ISP 15 days in advance of the scheduled ISP Meeting. |
| **Status at mid-cycle** |  For five individuals, support strategies had been submitted within the required timeline. For four individuals, support strategies were not submitted within the required timeline. However, in three instances the agency was either not provided with sufficient notice of the ISP meeting date, or unable to enter the support strategies into HCSIS. The agency needs to ensure that all support strategies are submitted in preparation for the ISP 15 days in advance of the scheduled ISP meeting. |
| **#met /# rated at mid-cycle** |  5/6 |
| **Rating** | MET |
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| **Indicator #** | L90 |
| **Indicator** | Personal space/ bedroom privacy |
| **Area Need Improvement** | Three out of eleven individuals did not have locks on their bedroom doors to allow them privacy. The agency needs to ensure that all individuals, unless clinically contraindicated or if the bedroom leads to an egress, have locks on their bedroom doors to provide the option of privacy. |
| **Status at mid-cycle** |  Eight individuals reviewed were observed to have privacy in their personal space. |
| **#met /# rated at mid-cycle** |  8/8 |
| **Rating** | MET |
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| **Indicator #** | L91 |
| **Indicator** | Incident management |
| **Area Need Improvement** | In two homes incident reports were not submitted within the required timelines. The agency needs to ensure that all incidents are submitted and finalized as mandated by regulation. |
| **Status at mid-cycle** |  Incident reports at five of six locations were submitted and finalized within required timelines. At one location, four incidents were either not submitted and/or finalized within required timelines. |
| **#met /# rated at mid-cycle** |  5/6 |
| **Rating** | MET |
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| **Mid-Cycle Detail Report** |

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| ***For provider and area office use only. This page elaborates on all of the indicators reviewed at follow-up where the standard was not met.*** |

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| **Residential and Individual Home Supports** |  |  |  |  |  |
| **Indicator** |  | **Service Type** | **Location** | **Individual** | **Issue** |
|  | L8 | Placement Services | 52 BISHOP STREET  |  CR | The individual's emergency fact sheet was missing required information, including information on his significant behavioral characteristics, response to search efforts, patterns of movement, places frequented, and relevant capabilities, limitations, and preferences. (Corrected) |
| O | L12 | Placement Services | 11 Adams Street  |   | The carbon monoxide detector was not within 10 feet of EM's bedroom (Corrected). The carbon monoxide detector on the second floor (main living space) was not plugged in (Corrected). |
|  | L35 | Placement Services | 100 Union St.  |  LR | The need for a bone density test due to her long term polypharmacy use has not been discussed with LR's HCP. It is not known when LR received her last Tetanus booster. |
|  | L35 | Placement Services | 43 E PLAIN ST  |  KL | It is not known when KL received her last Tetanus booster. |
|  | L36 | Placement Services | 11 Adams Street  |  EM | The endocrinologist suggest that EM take his blood sugars. There is no guidance on how frequently this should be occurring. On the day of the review the glucometer was not functioning as the battery was dead. |
|  | L36 | Placement Services | 43 E PLAIN ST  |  KL | During a 11/2020 appointment with KL's pulmonologist it was noted that a B12 work-up be conducted. This has not occurred. |
|  | L36 | Individual Home Supports | 62 Dunham Street 2nd Fl. |  CC | The individual has a number of related medical diagnoses that are managed by more than one healthcare specialist. There are confusing orders from the individual's PCP and cardiologist regarding the amount of weight gain to be reported to the cardiologist, and on 1/26/21 his cardiologist noted on an HCP form that vital signs reporting was no longer necessary. Despite this directive, the individual is currently having his blood pressure and weight taken four times a week (2x by agency staff and 2x by his day program staff). The agency needs to work with his PCP and healthcare specialists to clarify any conflicting orders. |
|  | L36 | Individual Home Supports | 847 PARK STREET Hope Gardens, Apt. B308 |  RD | The individual had conflicting orders in place for his fluid restriction; one from his cardiologist was for 1 liter/day and the other confirmed by his VNA nurse was for 2 liters/day. It was unclear as to which fluid restriction amount the agency was following. The agency should work with his healthcare specialists to clarify any conflicting orders in place. |
| O | L38 | Placement Services | 11 Adams Street  |  EM | The healthcare management plan for EM's diagnosis of diabetes with neuropathy and venous stasis ulcers. The plan states to call 911 for muscle weakness/fatigue. Documentation shows that muscle weakness is occurring in his back several times a week, but staff stated this is his baseline, and 911 has not been called. The plan does not address what to do in the event EM is displaying signs of Hypo/Hyperglycemia. |
|  | L56 | Placement Services | 43 E PLAIN ST  |  KL | There is no plan to eliminate or fade the need for chemicals to be locked. This restriction is not noted in the ISP. |
|  | L61 | ABI-MFP Residential Services | 63 Carolyn Court  |  TC | RC has a hand splint and booties which prevent foot drop. There was no documentation of staff training on the application, frequency of safety checks, cleaning, or maintenance of either device. |
|  | L63 | Placement Services | 100 Union St.  |  LR | The medication treatment plan does not include Abilify. There is no baseline data present. |
|  | L63 | Placement Services | 11 Adams Street  |  EM | The medication treatment plan does not have a description of the behaviors to be controlled/modified. |
|  | L63 | Placement Services | 43 E PLAIN ST  |  KL | There are no coping strategies outlined to support KL to decrease or eliminate the need for CBD oil prior to medical/dental appointments |
|  | L64 | Placement Services | 100 Union St.  |  LR | The use of Abilify has not been included in the ISP |
|  | L68 | Placement Services | 100 Union St.  |  LR | There is no agreement in place regarding LR paying her portion of a family plan cell phone bill that has 4 lines. |
|  | L69 | ABI-MFP Residential Services | 63 Carolyn Court  |  TC | There were $150.00 of gift cards belonging to TC and held by the program in a locked drawer that were not accounted for on a tracking sheet. (Corrected) |
|  | L69 | Placement Services | 100 Union St.  |  LR | Group purchases are frequently made on the shared living providers credit card. There were several instances where the documentation present for eating at restaurants was only the credit card signature slip and there was no itemized receipt present. Therefor, it could not be determined how much LR should pay for her portion on group purchases and that she was paying an amount comparable to her meal choice when bills were divided evenly amongst all parties. |
|  | L69 | Placement Services | 11 Adams Street  |  EM | EM's total assets have exceed the allowable limits to maintain health insurance and/or Social Security Benefits. The agency has not explored protected saving options, such as an ABLE account. |
|  | L70 | ABI-MFP Residential Services | 63 Carolyn Court  |  SL | A Charges for Care letter issued on 1/1/21 to SL for an increase in charges did not give advanced notification. The effective date was noted as 1/1/21 in the letter. |
|  | L70 | ABI-MFP Residential Services | 63 Carolyn Court  |  TC | The letter is dated 1/1/21 and effective 1/1/21 which did not allow for 30 days advance notice for the change in charges. |
|  | L70 | Placement Services | 11 Adams Street  |  EM | The charges for care letter was not calculated correctly. It states EM should be paying $933.00. He is actually paying $1026.75, which is 75% of his entitlements (Corrected). |
|  | L86 | Placement Services | 100 Union St.  |  LR | The assessments due on 11/18/20 were submitted on 11/19/20. |
|  | L86 | Placement Services | 43 E PLAIN ST  |  KL | The assessments due on 5/17/2020 were submitted 5/21/2020. This occurred during the peak of the pandemic. |
|  | L86 | Placement Services | 52 BISHOP STREET  |  CR | The individual's three ISP assessments were submitted on 12/1/20, nine days prior to his 12/10/20 ISP meeting date. |
|  | L87 | Placement Services | 100 Union St.  |  LR | The support strategies due on 11/18/20 were submitted on 11/19/20. |
|  | L87 | Placement Services | 43 E PLAIN ST  |  KL | The support strategies due on 5/17/2020 were submitted 5/21/2020. This occurred during the peak of the pandemic. |
|  | L87 | Placement Services | 52 BISHOP STREET  |  CR | The individual's two ISP support strategies were submitted on 12/1/20, nine days prior to his 12/10/20 ISP meeting date. |
|  | L87 | Individual Home Supports | 62 Dunham Street 2nd Fl. |  CC | As of 4/7/21, no objectives had been created in HCSIS for this individual. The agency reported that they were unable to enter CC's support strategies into HCSIS and provided documentation that they had notified his DDS Service Coordinator of the problem. |
|  | L91 | ABI-MFP Residential Services | 63 Carolyn Court  |   | 2 incidents were submitted outside the timelines, and two were submitted and finalized beyond the timelines. |
|  | L91 | Individual Home Supports | 847 PARK STREET Hope Gardens, Apt. B308 |   | Six incident reports were entered into HCSIS during review look-back period. One incident (#871999) was not finalized within seven business days, and another (#928043) was not submitted within three days of the event. One event (#871999) occurred during COVID-19 review period and the other was reported within three days of agency staff becoming aware of the event. |

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