DEPARTMENT OF DEVELOPMENTAL SERVICES
LICENSURE AND CERTIFICATION
PROVIDER FOLLOW-UP REPORT

Provider: Aspire Living and Learning

Provider Address: 80 Erdman Way, Suite 103A , Leominster

Name of Person Completing Form: Rachelle Asante

Date(s) of Review: 02-JUN-21 to 27-JUL-21

Follow-up Scope and results :		
Service Grouping	Licensure level and duration	# Indicators std. met/ std. rated
Employment and Day Supports	2 Year License	5/6
Residential and Individual Home Supports	Defer Licensure	3/7

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Summary of Ratings

Residential and Individual Home Supports Areas Needing Improvement on Standard not met - Identified by DDS

Indicator #	L5
Indicator	Safety Plan
Area Need Improvement	For four locations, safety plans did not reflect current staff ratios or evacuation strategies. In two other locations, the safety plan did not include all residents of the home who require support during evacuation. The agency needs to ensure it revises its safety plans when staffing patterns and/or evacuation strategies change and that it references each household member who may require support to evacuate.
Process Utilized to correct and review indicator	All existing Shared Living and 24/7 Residential EESP's were reviewed for accuracy. Those that were identified as being incorrect whether that was due to insufficient staffing noted, incorrect notation of supports needed to evacuate, older plans with Aspire's old name (IPPI), etc. were updated and submitted to the North Central Area Office for review and approval. In an effort to ensure accuracy, the Director of Adult Services will review all Safety Plans prior to their submission to DDS. This plan will be in effect for approximately 1 year. Within that 1-year period, the Director of Adult Services will identify who, if anyone, needs additional support to thoroughly and accurately complete the reports and training will be provided as needed.
Status at follow-up	Plans in need of revisions were identified, revised and submitted to Area Office for review and approval.
Rating	Met

Indicator #	L27

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Indicator	Pools, hot tubs, etc.
Area Need Improvement	At one location, entry to the pool was not locked when it was not in use, and policies and procedures describing supervision and safety of the individual using the pool were not in place. The agency must ensure safety and security of sites with swimming pools, including confirmation that access is locked when pools are not in use and that policies and procedures for supervision of the individual and safety of the location's pool are in place.
Process Utilized to correct and review indicator	The Shared Living Coordinators trained each provider during this follow up period as it relates to their home setting; looking at securing pools, hot tubs and upon traveling destinations with pools and where is the closest body of water; lakes, rivers etc. near their home. This will be an annual training and upon annual environment review the pools and all safeguards will be checked and documented on the form.
Status at follow-up	Placement settings affected were identified. At these settings, locks have been verified to be in place, providers are trained in CPR and water safety, and individuals are assessed for water safety/supervision needs. Check for locks has been added to quarterly and annual environmental checklists.
Rating	Met

Indicator #	L56
Indicator	Restrictive practices
Area Need Improvement	At one location, agreement for an environmental restriction was not obtained from the legal guardian. In addition, for individuals at the location for whom the restriction is not required, they and their guardians had not been informed of the restriction or the plan in place to mitigate the impact of the restriction. The agency needs to ensure that environmental restrictions intended to protect the safety of an individual have been incorporated into the individual's ISP.

	Individuals not subject to the restriction need to be informed, or their legal guardian informed, of the plan to mitigate the restriction's impact.
Process Utilized to correct and review indicator	The program where this was specifically identified has sent impact forms to guardians of those for whom the restriction is not required. The restriction plan was was agreed to by the guardian of the individual who requires it and was reviewed at our July Human Rights Committee (HRC) meeting.
Status at follow-up	HRC review is completed and guardians either have agreed to the restriction in place or been informed of the restriction and its impact on and mitigation plan for individuals not subject to the restriction.
Rating	Met

Indicator #	L63
Indicator	Med. treatment plan form
Area Need Improvement	For six individuals with medication treatment plans, required components of plans were not fully addressed. When medications are administered to manage or treat challenging behaviors, the agency needs to ensure behaviors targeted for treatment with the medication are observable and measurable as well as associated with the medications prescribed to treat them; procedures to minimize the risks of taking the medication(s) are defined; and clinical indications for reducing or eliminating the use of the medication are included. Target behavior data also needs to be collected and tracked so it may be shared with the prescriber to evaluate medication effectiveness.
Process Utilized to correct and review indicator	There is a medication treatment plan procedure that was reviewed with the clinical team and team members were trained on how to properly define behaviors is observable and measurable terms, define the procedures to minimize risk, and include the clinical indications for reducing or eliminating the medication. Clinicians

	have also created specific behavior tracking via Therap for target behaviors defined in the medication treatment plan. In addition to the above training and updates, a form has been created to aid in the creation of the medication treatment plan. The form will be completed once annually with the prescriber prior to the ISP date and whenever a new psychiatric medication is prescribed.
Status at follow-up	Specific data collection is in place and plans that were marked as not met at the time of review have been updated to address missing components. All plans are being reviewed to identify areas in need of correction, with corrections being made to follow. We are also updating our Med Treatment Plan template to include documentation of any conversations with the prescriber around decreasing medication due to the individual meeting criteria to do so.
Rating	Not Met

Indicator #	L67
Indicator	Money mgmt. plan
Area Need Improvement	For six individuals who receive support to manage their personal funds, the funds management plan did not match the supports provided to the individual and/or written agreement to the plan had not been obtained from the individual or guardian. The agency needs to ensure that when individuals require support to manage their personal fuds, a funds management plan is developed that accurately reflects the supports the individual requires, and written agreement to the plan is obtained from individuals or guardians.
Process Utilized to correct and review indicator	During the September's Managers meeting, all Program Managers, and Shared Living Coordinators will be trained in Aspire's Money Management Procedure. Any managers and/or coordinators not in attendance will be trained by their direct Supervisor no later than October 15th. All Money Management Training/Teaching Plans identified has "not

	met" during the original full audit from OQE will be revised. Staff and/or Shared Living Providers will receive training on the revised plan no later than December 31st.
Status at follow-up	No changes; indicator correction in process.
Rating	Not Met

Indicator #	L86
Indicator	Required assessments
Area Need Improvement	For four individuals, the agency had not submitted ISP assessments within required timeframes. The agency needs to ensure that assessments are submitted at least 15 days in advance of the ISP.
Process Utilized to correct and review indicator	With the help of our administrative team, we have created a document that outlines every individual in our services as well as the date of their last ISP. This document will allow us to send out monthly reminders to the individual's team of whose ISP is coming up within the next 3 months. This will ensure that the Aspire team, in collaboration with the DDS team, is working to schedule the upcoming ISP therefore giving us the required timeline for document submission into HCSIS. We have worked to streamline our pre-ISP process in an effort to get the internal team's input prior to completion of the documents in HCSIS. Once an ISP meeting has been completed, the designated Program Manager or Shared Living Coordinator is responsible for notifying the administrative team so that the spreadsheet can be updated.
Status at follow-up	Only 64% of assessments submitted during the follow-up period were on time, and a new plan is underway to address.
Rating	Not Met

Employment and Day Supports Areas Needing Improvement on Standard not met - Identified by DDS

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Indicator #	L5
Indicator	Safety Plan
Area Need Improvement	For CBDS services provided in in two agency-operated residential locations, an approved safety plan was not in place for the supports provided by the day service. The agency needs to ensure that a safety plan is developed and approved when staff providing day service supports are responsible for safe evacuation of individuals.
Process Utilized to correct and review indicator	No Walls Emergency Evacuation Safety Plans have been created for all of the 15 locations where we are providing CBDS services from the residential locations in a No Walls model. Since this is a unique situation, Aspire has been in touch with Andrea Helie from the North Central office with clarifying questions. All 15 plans have been completed, submitted on July 27, 2021, and we are currently waiting for Provider Assurance sign offs from the North Central Office. Once these plans are approved, our CBDS management staff will ensure that all CBDS staff are trained on the new EESPs. These plans will be added to our existing EESP expiration spreadsheet so they can be reviewed every 2 years or as individual's evacuation needs change or staffing ratios change in the program in accordance with DDS regulations.
Status at follow-up	All 15 plans have been completed and submitted on July 27, 2021 to Area Office for review and approval. Plans are waiting for signed Provided Assurance Form from Area Office.
Rating	Met

Indicator #	L56
Indicator	Restrictive practices
Area Need Improvement	For one individual, an environmental restriction of door chimes/alarms remained in place during day service hours when the individual for whom the restriction was developed was not in attendance. The agency needs to ensure that plans to mitigate the

	impact of environmental restrictions are followed as written for individuals not subject to the intervention.
Process Utilized to correct and review indicator	All staff who work in programs where there are restrictions that impact other individuals have been retrained on the part of the restriction plan that indicates the plan to mitigate the impact of the environmental restriction on those form whom the restriction does not apply. This plan has always been a part of our restriction plans; however, it will be a more specific and lengthy talking point during training moving forward. It will also be underlined and in bold on the restriction plans so as to draw staff's attention to the importance of this piece of the restriction.
Status at follow-up	Staff who work in programs where there are restrictions that impact other individuals have been retrained.
Rating	Met

Indicator #	L67
Indicator	Money mgmt. plan
Area Need Improvement	For three individuals who received support to manage spending money from day service staff, the funds management plan did not describe the supports provided to the individual or written agreement to the plan had not reviewed and agreed to by the individual. The agency needs to ensure that funds management plans fully describe the supports provided by the agency and that agreement to the plan is obtained from the individual or legal representative.
Process Utilized to correct and review indicator	Since the support the individual is receiving with money management is mirrored across both day/residential/shared living services, we have begun to incorporate on one form, how the individual will be supported across all service areas. This will eliminate the need for separate plans that address the same area of need/support. When the time comes that we have the ability to re-

	open our CBDS services to full capacity, at that time, we will reevaluate all of our day only individuals and create separate and person-centered money management training plans for each of them. These plans will be reviewed with both the individual and the guardian for their approval and signature.
Status at follow-up	Support of individuals with their funds during Without Walls CBDS programming and outings now includes cash in/out (or debit as applicable), and receipts and balances are tracked, consistent with how individuals are supported to manage their funds during residential hours. CBDS staff working in Without Walls have been trained in this new system as well.
Rating	Met

Indicator #	L69
Indicator	Expenditure tracking
Area Need Improvement	For one individual, CBDS staff held the individual's funds and collected receipts for purchases but tracking of funds received from and returned to the individual's residence were not tracked. When agency staff hold individuals' funds and provide support in the use of funds, amounts received and returned on behalf of the individual need to be tracked.
Process Utilized to correct and review indicator	A cash on hand sheet was created and implemented. This form includes the cash on hand balance, money added in (change from a purchase or initial receipt of funds), money taken out, a place to log in where the money was spent, a place to indicate if the purchase was made with cash or an individual's debit card, as well as staff's signature. All CBDS staff were trained in the requirement to use this form for each and every transaction. In the No Walls CBDS programs, a binder was created and it being kept on a bookshelf in each program's office. This allows for consistent placement across programs so that staff are easily able to locate the binder where they need to document any funds withdrawn or added in.

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Status at follow-up	Cash on hand sheet with expense tracking was created and implemented.
Rating	Met

Indicator #	L78
Indicator	Restrictive Int. Training
Area Need Improvement	CBDS staff had not consistently implemented the plan to mitigate the impact of an environmental restriction on an individual for whom the restriction was not required. The agency needs to ensure its day support staff are trained to consistently implement restrictive interventions, including provisions for mitigating the impact on individuals not subject to the restriction.
Process Utilized to correct and review indicator	All staff who work in CBDS programs where there are restrictions that impact other individuals have been retrained on the part of the restriction plan that indicates the plan to mitigate the impact of the environmental restriction on those form whom the restriction does not apply. This plan has always been a part of our restriction plans; however, it will be a more specific and lengthy talking point during training moving forward. It will also be underlined and in bold on the restriction plans so as to draw staff's attention to the importance of this piece of the restriction.
Status at follow-up	Staff who work in programs where there are restrictions that impact other individuals have been retrained.
Rating	Met

Administrative Areas Needing Improvement on Standard not met - Identified by DDS

Indicator #	L65
Indicator	Restraint report submit

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Area Need Improvement	Restraint reports were not filed or finalized within required timelines for 14 of 35 reports reviewed. The agency needs to ensure that restraint reports are created in HCSIS within 3 calendar days of the restraint and reviewed and finalized within 5 calendar days as required.
Process Utilized to correct and review indicator	We are taking a team-based approach on working toward 100% compliance in this area. All team members will send "friendly reminders" to those involved to ensure that restraint reports have been entered into HCSIS within the assigned timeline. Our administrative team is also helping us to achieve this goal by running HCSIS reports 3 times per week of reportable incidents. This allows management to follow up with the involved parties to ensure that they are adhering to timelines. Additionally, we conducted an internal training for all managers at our June 2021 monthly Practical Tuesday Meeting on the HCSIS Incident Report and Restraint Report requirements which included not only incident categories, but also timelines associated with those categories.
Status at follow-up	Administrative team is running reports of HCSIS reports 3 times per week. After a restraint/incident occurs, team members are reminding each other of HCSIS timeline. A total of 9 restraints were filed in the past 60 days. Of these, only one restraint report was both created on time (within 3 days) and finalized on time (within 5 days of the restraint occurring). Managers will re-evaluate and discuss new methods to ensure restraint filing/approval timelines are met consistently.
Rating	Not Met