

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 Rachelle Asante
Completing Form: _____

Date(s) of Review: 02-FEB-26 to 04-FEB-26

Follow-up Scope and results :		
Service Grouping	Licensure level and duration	# Indicators std. met/ std. rated
Employment and Day Supports	2 Year License	2/5
Residential and Individual Home Supports	2 Year License	3/9

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

Indicator #	L15
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Indicator	Hot water
Area Need Improvement	At three of fourteen locations, water temperatures tested outside the recommended range of 110-120°F. The agency should ensure that water temperature is maintained within the recommended range at all locations.
Process Utilized to correct and review indicator	<p>Regulations related to water temperature were reviewed with the entire Aspire team.</p> <p>Using the JotForm system, water temperature check has now been added to the Fire Drill form. Programs are now expected to test and document water temperature at time of fire drill. In Shared Living settings, coordinators test and document water temperature quarterly during the monthly site visits.</p> <p>On a quarterly basis, the Director of Program Supports or designee analysis the JotForm tracking and reporting grid to monitor compliance.</p> <p>Fire drill submissions were reviewed for accuracy. Of the ten submissions reviewed, six indicated water temperatures outside of the acceptable range.</p>
Status at follow-up	Our current regulatory compliance process requires modification as they are not delivering the level of effectiveness needed alongside enhanced training to ensure clear understanding, consistent execution and accountability across the organization.
Rating	Not Met

Indicator #	L43
Indicator	Health Care Record

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Area Need Improvement	For five of seventeen individuals, health care records were not updated or completed as required. The agency must ensure that health care records are updated annually at the time of the ISP and within 30 days of all annual physical, dental, vaccinations, new diagnoses, and testing to include the most recent health information.
Process Utilized to correct and review indicator	<p>Regulations related to Health Care Record were reviewed with Managers, Coordinators and their supervisor.</p> <p>Aspire has established a procedure requiring that any documentation created outside of the Therap system be uploaded and stored in Therap to support internal auditing processes. This procedure was reviewed with Managers and Coordinators to ensure understanding and compliance.</p> <p>The internal review process for critical incidents, based on established internal criteria, includes structured prompts to ensure all required documentation is completed and that the individual's health care record is accurately updated.</p> <p>A review of Critical Incidents from January 1, 2025, through January 28, 2026, was conducted to determine whether additional documentation or updates to the Health Care Record (HCR) were required. The review determined that no additional updates were necessary during this timeframe. Based on employee self-reporting, Health Care Records are being updated in accordance with established requirements.</p>
Status at follow-up	System implemented and being monitored by Quality.
Rating	Met

Indicator #	L56
Indicator	Restrictive practices

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Area Need Improvement	For three of six individuals who lived in homes that had environmental restrictions in place to protect the health and safety of some residents, there were no written rationale for use of the restrictions, criteria for eliminating the restrictions, and/or the mitigation plan in place for those impacted by the restrictions were not being properly implemented. The agency must ensure that when restrictive interventions are in place, they are accompanied by written plans that outline written rationale for use of the restrictions, criteria for eliminating the restrictions, and mitigations for those impacted by the restrictions.
Process Utilized to correct and review indicator	Expectations related to restrictive practices were reviewed with Managers and Coordinators. Any identified deficiencies were addressed and corrected. 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. Aspire's Targeted Positive Behavior Support (PBS) Tier Committee has established an audit schedule to review applicable guidelines and communicate findings to all relevant team members.
Status at follow-up	Staff who work in programs where there are restrictions that impact other individuals have been retrained. System is implemented and is being followed my Quality.
Rating	Met

Indicator #	L60
Indicator	Data maintenance

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Area Need Improvement	For three of eight individuals, data on specific behaviors identified in behavior plans was not being consistently collected and maintained. The agency must ensure that data is consistently collected regarding the targeted behaviors outlined in behavior plans to determine the efficacy of behavioral interventions.
Process Utilized to correct and review indicator	<p>Regulations related to Data Collection were reviewed with managers, including their ability to generate and review reports in Therap with supervisees.</p> <p>A comprehensive list of responsibilities has been developed for Direct Support Professionals (DSPs) to reinforce work expectations. This list is posted in each designated work area for staff reference.</p> <p>Program Directors (PDs) review documentation at a minimum of once per month during supervision as part of established accountability measures.</p>
Status at follow-up	Inconsistent execution of this indicator. System implemented and being monitored by Quality.
Rating	Not Met

Indicator #	L86
Indicator	Required assessments
Area Need Improvement	For five of twelve individuals, required ISP assessments were not submitted at least 15 days prior to the ISP. The agency must ensure support strategies are submitted at least 15 days prior to the ISP Meeting.

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Process Utilized to correct and review indicator	Managers and Coordinators are expected to enter all due dates for upcoming ISPs, Support Strategies, and Progress Notes into their calendars. The Administrative Assistant generates HCSIS reports on a bi-monthly basis. Program Directors review documentation at a minimum of once per month during supervision as part of established accountability measures.
Status at follow-up	Less than 80% of assessments submitted during the follow-up period were on time. PDs have identified a new plan to address. System implemented and being monitored by Quality.
Rating	Not Met

Indicator #	L87
Indicator	Support strategies
Area Need Improvement	For five of twelve individuals, ISP support strategies were not submitted within the required timelines. The agency must ensure support strategies are submitted at least 15 days prior to the ISP Meeting.
Process Utilized to correct and review indicator	Managers and Coordinators are expected to enter all due dates for upcoming ISPs, Support Strategies, and Progress Notes into their calendars. The Administrative Assistant generates HCSIS reports on a bi-monthly basis. Program Directors review documentation at a minimum of once per month during supervision as part of established accountability measures.

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Status at follow-up	Less then 80% of Support Strategies submitted during the follow-up period were on time. PDs have identified a new plan to address. System implemented and being monitored by Quality.
Rating	Not Met

Indicator #	L88
Indicator	Strategies implemented
Area Need Improvement	For five of seventeen individuals, ISP goals for which the agency has designated responsibility were either not being implemented, or data was not being collected to show implementation. The agency must ensure that agreed upon goals are being implemented; and that data showing progress towards meeting the goals are collected and maintained.
Process Utilized to correct and review indicator	Supervisors expectations and oversight were reviewed, including their ability to generate and review reports in Therap with supervisees. Program Directors review documentation at a minimum of once per month during supervision as part of established accountability measures. Inconsistent execution of this indicator. Indicator correction in progress alongside enhanced training to ensure clearer understanding and consistent performance. System implemented and being monitored by Quality.

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Status at follow-up	<p>Supervisors expectations and oversight were reviewed, including their ability to generate and review reports in Therap with supervisees.</p> <p>Program Directors review documentation at a minimum of once per month during supervision as part of established accountability measures.</p> <p>Inconsistent execution of this indicator. Indicator correction in progress alongside enhanced training to ensure clearer understanding and consistent performance.</p> <p>System implemented and being monitored by Quality.</p>
Rating	Not Met

Indicator #	L99 (05/22)
Indicator	Medical monitoring devices
Area Need Improvement	For two of four individuals with medical monitoring devices, there was no written outline for the use of the devices. The agency must ensure that when individuals have medical monitoring devices, there is a written plan that outlines the rationale for use, authorization from a medical professional, and guidelines for cleaning and maintenance.
Process Utilized to correct and review indicator	<p>Expectations were reviewed during January's monthly managers meeting.</p> <p>Program Directors review documentation at a minimum of once per month during supervision as part of established accountability measures</p>

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Status at follow-up	Inconsistent execution of this indicator. Indicator correction in progress alongside enhanced training to ensure clearer understanding and consistent performance. System implemented and being monitored by Quality.
Rating	Not Met

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

Indicator #	L86
Indicator	Required assessments
Area Need Improvement	For three of eleven individuals, required ISP assessments were not submitted at least 15 days prior to the ISP. The agency must ensure support strategies are submitted at least 15 days prior to the ISP.
Process Utilized to correct and review indicator	Managers are expected to enter all due dates for upcoming ISPs, Support Strategies, and Progress Notes into their calendars. The Administrative Assistant generates HCSIS reports on a bi-monthly basis. Program Director (PD) reviews documentation at a minimum of once per month during supervision as part of established accountability measures
Status at follow-up	Less than 80% of assessments submitted during the follow-up period were on time. PDs have identified a new plan to address. System implemented and being monitored by Quality.
Rating	Not Met

Indicator #	L87
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Indicator	Support strategies
Area Need Improvement	For three of eleven individuals, required ISP support strategies were not submitted within the required timelines. The agency must ensure support strategies are submitted at least 15 days prior to the ISP.
Process Utilized to correct and review indicator	Managers are expected to enter all due dates for upcoming ISPs, Support Strategies, and Progress Notes into their calendars. The Administrative Assistant generates HCSIS reports on a bi-monthly basis. Program Director (PD) reviews documentation at a minimum of once per month during supervision as part of established accountability measures.
Status at follow-up	Less than 80% of Support Strategies submitted during the follow-up period were on time. PDs have identified a new plan to address. System implemented and being monitored by Quality.
Rating	Not Met

Indicator #	L88
Indicator	Strategies implemented
Area Need Improvement	For five of twelve individuals, ISP goals for which the agency has designated responsibility were either not being implemented or data was not being collected to show implementation. The agency must ensure that all agreed upon ISP goals are being implemented and that data showing progress towards meeting the goals are collected and maintained.

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Process Utilized to correct and review indicator	Supervisors expectations and oversight were reviewed, including their ability to generate and review reports in Therap with supervisees. Program Director reviews documentation at a minimum of once per month during supervision as part of established accountability measures.
Status at follow-up	Inconsistent execution of this indicator. Indicator correction in progress alongside enhanced training to ensure clearer understanding and consistent performance. System implemented and being monitored by Quality.
Rating	Not Met

Indicator #	L91
Indicator	Incident management
Area Need Improvement	At one day service location, incident reports were not submitted and/or finalized within the required timelines. The agency must ensure that all incident reports are submitted and finalized within the required timelines in HCSIS.
Process Utilized to correct and review indicator	The Administrative Assistant generates HCSIS reports three times per week and shares the results with the Adult Services team.
Status at follow-up	These reports are also reviewed as part of the data analysis conducted during supervision. After a restraint/incident occurs, team members are reminding each other of HCSIS timeline.
Rating	Met

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

Indicator #	L48
Indicator	HRC
Area Need Improvement	The agency's human rights committee did not have a legal representative. The agency must ensure that its committee includes all requisite specialty members and that they attend human rights committee meetings regularly.
Process Utilized to correct and review indicator	Aspire recruited a law student. He attended the December meeting and will continue to attend meetings as scheduled quarterly.
Status at follow-up	New recruit attended the December meeting. He is committed to continue to attend the meetings as scheduled quarterly.
Rating	Met