DEPARTMENT OF DEVELOPMENTAL SERVICES

LICENSURE AND CERTIFICATION

DDS FOLLOW-UP REPORT

Provider	BERKSHIRE HILLS MUSIC ACADEMY	Provider Address	48 Woodbridge St , South Hadley
Survey Team	Comeau, Andrea; Adorno, Elsa;	Date(s) of Review	15-FEB-23 to 17-FEB-23

Follow-up Scope and results :

Service Grouping	Licensure level and duration	# Critical Indicators std. met/ std. rated at follow-up	# Indicators std. met/ std. rated at follow-up	Sanction status prior to Follow-up	Combined Results post-Follow-up; for Deferred, License level	Sanction status post Follow-up
Employment and Day Supports 2 Locations 12 Audits	2 Year License		4/6	☒ Eligible for new business (Two Year License) ☐ Ineligible for new business. (Deferred Status: Two year mid-cycle review License)	2 Year License	☒ Eligible for New Business (80% or more std. met; no critical std. not met) ☐ Ineligible for New Business (<=80% std met and/or more critical std. not met)
Residential and Individual Home Supports 3 Locations 10 Audits	Defer Licensure		6/8	☐ Eligible for new business (Two Year License) ☒ Ineligible for new business. (Deferred Status: Two year mid-cycle review License)	2 Year License	☒ Eligible for New Business (80% or more std. met; no critical std. not met) ☐ Ineligible for New Business (<=80% std met and/or more critical std. not met)

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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	In three locations, current signed Emergency Evacuation Safety Plans were not onsite. The agency needs to ensure that Emergency Evacuation Safety Plans reflecting the evacuation support needs of the current occupants, are current, are approved by the DDS Area Office and are located onsite.
Status at follow-up	
#met /# rated at followup	
Rating	Not Rated

Indicator #	L12
Indicator	Smoke detectors
Area Need Improvement	In one placement location a smoke detector was not located outside the sleeping area. Additionally, at two placement locations carbon monoxide detectors were not located within ten feet of the individuals' bedrooms. The agency needs to ensure that smoke and carbon monoxide detectors are located where required and are operational.
Status at follow-up	
#met /# rated at followup	
Rating	Not Rated

Indicator #	L46
Indicator	Med. Administration
Area Need Improvement	For one individual in 24-hr. residential services, who required support in taking medication, Medication Administration Procedures (MAP) were not being consistently followed. The agency needs to ensure that MAP procedures are consistently followed within 24-hr residential services, for individuals who require support in taking their medication. Additionally, for four individuals in placement services who receive assistance from care providers with

	medication administration, current, signed medication orders were not present in the home. The agency needs to strengthen its oversight of medication administration in placement services to ensure that current, signed medication orders are present at the home and care providers administer medications consistent with physicians' orders.
Status at follow-up	
#met /# rated at followup	
Rating	Not Rated

Indicator #	L63
Indicator	Med. treatment plan form
Area Need Improvement	For four individuals, medication treatment plans did not include all required elements. The agency needs to ensure that for individuals who are prescribed behavior modifying medications, a medication treatment plan is developed to include observable and measurable descriptions of each behavior targeted for treatment; clinical indications for adjusting medications; and specific procedures necessary to minimize risks.
Status at follow-up	In response to findings from the current licensing review, the agency is in the process of revising its format and instructions for developing medication treatment plans to ensure all required components are included. At the point of follow-up, BHMA had initiated revisions to some medication treatment plans, with the goal of reviewing all MTPs for currency and accuracy. Medication treatment plans were reviewed for five individuals sampled within IHS, placement services and 24-hour residential services. All plans were current but did not contain all required elements, including a detailed description of the target behaviors and the procedures utilized to minimize risk.
#met /# rated at followup	0/5
Rating	Not Met

Indicator #	L67
Indicator	Money mgmt. plan
Area Need Improvement	For four individuals, funds management plans did not address all required elements. Additionally, for one individual requiring assistance with money management, there was no funds management plan in place. When the agency assumes shared or delegated responsibility for managing an individual's funds, the agency needs to develop funds management plans that outline the roles and

	responsibilities of the agency in supporting individuals to manage and spend their personal funds to include how money is safeguarded within the home. These plans must be individualized and are subject to annual written agreement from the individual or his/her guardian.
Status at follow-up	
#met /# rated at followup	
Rating	Not Rated

Indicator #	L86
Indicator	Required assessments
Area Need Improvement	For four individuals, ISP assessments were not submitted to DDS within 15 days prior to the ISP. The agency needs to ensure that ISP assessments are submitted to DDS within 15 days prior to the ISP.
Status at follow-up	BHMA created a notification system to alert staff 6 weeks prior to the ISP date. Once notification has been received, responsible staff will ensure all required assessments have been uploaded to HCSIS at least 15 days prior to the ISP. There was one individual in IHS who had an ISP meeting early in the 60-day follow-up period, where required timelines were not met.
#met /# rated at followup	0/1
Rating	Not Met

Indicator #	L94 (05/22)
Indicator	Assistive technology
Area Need Improvement	For twelve individuals, support needs and the potential benefits of assistive technology had not been assessed. The agency needs to ensure that all individuals are assessed to identify assistive technology to maximize independence and provide these supports when a need is identified.
Status at follow-up	
#met /# rated at followup	
Rating	Not Rated

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

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Indicator #	L36
Indicator	Recommended tests
Issue Identified	2/8 Met SL In multiple locations, individuals did not have documented follow-up appointments with various providers and/or requested lab work completed 3/3 Met ABI 5/6 Met in Res JMC - 21 Redemption Rock Trail Princeton no follow up with Podiatrist within timeframe recommended.
Actions Planned/Occurred	Aspire will use our existing supervisory process and internal audit structure to improve compliance around scheduling all recommended appointments and/or tests. The supervision process includes review of any action steps identified by internal audits, to include follow-up with recommended medical tests & appointments. In Shared Living, Coordinators were given a deadline to upload the monthly visit form to Therap. The Program Director will be completing monthly audits to ensure compliance.
Status at follow-up	
Rating	Not Rated

Indicator #	L43
Indicator	Health Care Record
Issue Identified	0/3 Met ABI GB - supportive devices section incomplete SE - emergency contact is outdated TD - No mammogram date recorded on HCR 7/8 Met SL 242 Rollstone Rd., Fitchburg - 2022 & 2023 Hospital visits are not documented. 6/6 Met Res
Actions Planned/Occurred	Aspire will be modifying two JotForms already in use so that we can incorporate, within our existing systems, additional reminders and prompts for staff to update Health Care Records when necessary. Our Medical Audit tool will be updated by October 1st to include a section specifically outlining missing components of the HCR. Staff will then be held accountable for promptly addressing these missing components through our supervisory process. Aspire conducts an internal review process for all incidents that we deem critical. As these Critical Incidents include events that would require HCR updates (emergency room visits, etc), we will add a question, by October 1st, about whether the HCR needs to be updated to the JotForm used in this

	review process.
Status at follow-up	BHMA reviewed and updated all Health Care Records. Updates will continue to be made within the DDS HCSIS system throughout the year as needed as well as at the time of the ISP. During follow-up, Health Care Records were reviewed for four individuals receiving individual home supports and placement services and all four records were current and up to date.
Rating	Met

Indicator #	L88
Indicator	Strategies implemented
Issue Identified	3/3 Met ABI 6/8 Met SL 133 Betty Springs Rd., Gardner - provider is not aware of the goal 60 Thomas St., Fitchburg - provider is not aware of the goal 4/6 Met Res For two individuals at 26 James Road, Sterling (RT & SL), data is not being taken for ISP goal.
Actions Planned/Occurred	Shared Living Coordinators use a monthly visit form to document conversations with Shared Living Providers. The section on this form pertaining to ISP Progress Note / Data has been revised to facilitate more thorough discussion and review of ISP goals and data collected. As described above, Aspire is actively working to increase data collection across residential programs. We anticipate that the monthly report of each program's data collection rates and Adult Services Leadership goal of 5% increase in behavioral data collection quarterly will lead to an increase in data collected for ISP goals. In addition, beginning in October, we plan to begin internally auditing staff meeting agendas, as there is an agency expectation that data review is included in staff meetings. Staff meeting attendance forms are uploaded into our Training Management System along with the staff meeting agendas. This will allow for easy auditing to take place at any time, from any location. A training will be conducted in September 2023, showing Program Managers how to run a report from Therap on ISP data collection. This will also be added to as a standing agenda item to monthly staff meetings. By 12.31.23 Program Managers will be required to add the semi-annual progress summary due date to their Outlook calendars which will be verified by the Program Director.
Status at follow-up	
Rating	Not Rated

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

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Indicator #	L88
Indicator	Strategies implemented
Issue Identified	5/5 Met Employment 5/9 Met CBDS For multiple individuals, there is no data to support goal or no progress summaries in HCSIS
Actions Planned/Occurred	As described in a previous section of the report, Aspire is actively working to increase data collection across residential programs. We anticipate that the monthly report of each program's data collection rates and Adult Services Leadership goal of 5% increase in behavioral data collection quarterly will lead to an increase in data collected for ISP goals. In addition, beginning in October, we plan to begin internally auditing staff meeting agendas, as there is an agency expectation that data review is included in staff meetings. Staff meeting attendance forms are uploaded into our Training Management System along with the staff meeting agendas. This will allow for easy auditing to take place at any time, from any location. A training will be conducted in September 2023, showing Program Managers how to run a report from Therap on ISP data collection. This will also be added to as a standing agenda item to monthly staff meetings. By 12.31.23 Program Managers will be required to add the semi-annual progress summary due date to their Outlook calendars which will be verified by the Program Director.
Status at follow-up	
Rating	Not Rated

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

Indicator #	L94 (05/22)
Indicator	Assistive technology
Area Need Improvement	For fifteen individuals, support needs and the potential benefits of assistive technology had not been assessed. The agency needs to ensure that all individuals are assessed to identify assistive technology to maximize independence and provide these supports when a need is identified.
Status at follow-up	
#met /# rated at followup	
Rating	Not Rated

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

Indicator #	L65
Indicator	Restraint report submit
Area Need Improvement	Of twenty-three restraint reports reviewed, six were not submitted within the required timelines. The agency needs to ensure restraint reports are written and submitted to DDS within the required timelines.
Status at follow-up	
#met /# rated at followup	
Rating	Not Rated

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

Indicator #	L76
Indicator	Track trainings
Issue Identified	7 of 20 employees sampled fully met the standard with complete training records.
Actions Planned/Occurred	A new mandatory training tracking grid has been developed for managers to monitor all staff's trainings, with an implementation date of July 7th. We will audit for compliance with this tool by the end of September 2023. Staff training records are audited by our quality team 2x/year in July and December. The auditing process includes the use of a JotForm, which has been developed for this purpose. The JotForm is emailed to the Program Manager, Program Director, and Director of Adult Services. Action items are outlined in the JotForm with a deadline for completion. Once completed, the 2nd level manager must spot check for accuracy and approve the completion of the action items. All of these steps are tracked within the JotForm. Action Plans are created for necessary areas of need with identified timelines.
Status at follow-up	
Rating	Not Rated

Indicator #	L83
Indicator	HR training

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Issue Identified	13 of 20 employees sampled met this standard; the majority of those that did not meet the standard were recently expired in July 2023.
Actions Planned/Occurred	A new mandatory training tracking grid has been developed for managers to monitor all staff's trainings, with an implementation date of July 7th. We will audit for compliance with this tool by the end of September 2023. Staff training records are audited by our quality team 2x/year in July and December. The auditing process includes the use of a JotForm, which has been developed for this purpose. The JotForm is emailed to the Program Manager, Program Director, and Director of Adult Services. Action items are outlined in the JotForm with a deadline for completion. Once completed, the 2nd level manager must spot check for accuracy and approve the completion of the action items. All of these steps are tracked within the JotForm. Action Plans are created for necessary areas of need with identified timelines.
Status at follow-up	
Rating	Not Rated

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