DEPARTMENT OF DEVELOPMENTAL SERVICES

LICENSURE AND CERTIFICATION

DDS FOLLOW-UP REPORT

Provider	CADMUS LIFESHARING ASSOCIATION	Provider Address	80 Maple Ave. , Great Barrington
Survey Team	Adorno, Elsa; Jones, Ken;	Date(s) of Review	06-JUL-23 to 11-JUL-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 1 Locations 4 Audits	2 Year License	1/1	5/6	☒ Eligible for new business (Two Year License) ☐ Ineligible for new business. (Deferred Status: Two year mid-cycle review License)	2 Year License with Mid-Cycle Review	☒ 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 4 Audits	Defer Licensure		14/21	☐ Eligible for new business (Two Year License) ☒ Ineligible for new business. (Deferred Status: Two year mid-cycle review License)	2 Year License with Mid-Cycle Review	☒ 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	Cadmus took specific steps to strengthen its monitoring capacity for the review of safety plans to ensure that they were current and approved by DDS for all placement service locations. All plans were reviewed for accuracy and whether the plans received DDS approval, including documentation of staff training at the site. A centralized safety plan tracking system was developed, maintained, and monitored at the agency's administrative assistant's office. The tracking system identified safety plan due dates for plans to be re-filed. Safety plans are also checked on by the case coordinator during the monthly home visits to ensure that they are current. The presence of DDS approved safety plans and staff trainings were reviewed at three locations included in the follow-up sample. Findings showed that all three locations reviewed had current DDS approved safety plans and all assigned staff per location were trained.
#met /# rated at followup	3/3
Rating	Met

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

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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	The agency developed a tracking document to improve its capacity to ensure that medication treatment plans are reviewed and submitted as supporting document for the ISP process. The agency's administrative assistant is responsible for notifying agency staff and the case coordinator of these respective due dates. The agency however lacks internal expertise in developing medication treatment plans and have expressed the possibility of requesting support from prescribers at an area clinic (Brien Center). Four individuals' medication treatment plans were reviewed as part of this follow-up sample. Findings of the review showed that medication treatment plans that did not contain all the required components, including targets for success and criteria for having discussion with the prescriber regarding consideration for medication reduction. Also, medications prescribed as sedatives prior to medical or dental procedures did not have a plan to reduce the medication overtime and was not included in the ISP.

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#met /# rated at followup	0/4
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	Cadmus took steps to ensure that all individuals' funds management plans were in place. Records for sampled individuals were reviewed to ensure that they contained current funds management plans. The agency also reestablished a funds management policy and procedure that would benefit additional review and modification to fully address the requirements that are in place when assistance is provided to individuals in managing and spending their funds. Four individuals were selected as part of the follow-up sample. Findings of the review showed that for one individual the standard for funds management planning was not applicable at this point in time. For two of the individuals, the funds management plan did not contain all the required components that included how funds will be secured as well as strategies to strengthen oversight for the use of debit cards. Funds management plans also contained inaccurate information regarding cash amounts of money that would be maintained at the home.
#met /# rated at followup	1/3
Rating	Not Met

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	The agency developed an ISP tracking document to improve its capacity to submit ISP assessments within the required timelines. The agency's administrative assistant is responsible for overseeing all ISP timelines in addition to the case coordinator. Timeline alerts will be used to inform the agency as reminders of due dates for the submission of ISP assessments. One individual's ISP information was reviewed where the ISP meeting occurred. Findings showed that ISP assessments were submitted at least 15 days prior to the ISP meeting.
#met /# rated at followup	1/1
Rating	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	Cadmus took effective steps to ensure that individuals were assessed regarding the benefits of assistive technology. The agency utilized a standardized assistive technology assessment tool to evaluate all individuals and, in some instances, conclusions of the assessment made note of possible devices that the individuals could benefit from. In at least one instance, an external company was utilized to develop technology for the person to improve their communication capacity. Four individuals were reviewed as part of the survey sample. All four individuals had received an assistive technology assessment and were in the process of exploring potential options for each person.
#met /# rated at followup	4/4
Rating	Met

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

Indicator #	L36
Indicator	Recommended tests

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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	
Rating	Not Rated

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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

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

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	Cadmus took effective steps to ensure that individuals' ISP goals were being implemented. Staff reviewed all individuals' ISP documentation to discern whether ISP goals were documented as outlined in each person's ISP. Staff then ensured that each person's objectives had corresponding data tracking sheets to evaluate individual's implementation of ISP goals as stated. During case coordinators monthly visits to the home, ISP goal implementation will be checked on during discussions with home providers. Four individuals' ISP goals were reviewed as part of this follow-up sample. Findings of the review showed that all ISP goals were being implemented and tracked with corresponding data sheets.
Rating	Met

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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	Cadmus took effective steps to ensure that individuals were assessed regarding the benefits of assistive technology. The agency utilized a standardized assistive technology assessment tool to evaluate all individuals and, in some instances, conclusions of the assessment made note of possible devices that the individuals could benefit from. In at least one instance, an external company was utilized to develop technology for the person to improve their communication capacity. Four individuals were reviewed as part of the follow-up sample. All four individuals had received an assistive technology assessment and was in the process of exploring potential options for each person.
#met /# rated at followup	4/4
Rating	Met

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

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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
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