|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Provider | CAPE ABILITIES |  | Provider Address | 895 Mary Dunn Road , Hyannis | | Survey Team | Marchese, Michael; Gregory, Katherine; Napolitan, Tina; Mazzella, Barbara; Nolan, Scott; Boyd, Michelle; Condon, Kayla; |  | Date(s) of Review | 06-JUL-20 to 10-JUL-20 | |
|  |
| |  | | --- | |  | | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **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 | | | Residential and Individual Home Supports | 2 Year License with Mid-Cycle Review |  | 14/24 | o | Eligible for new business (Two Year License) | 2 Year License with Mid-Cycle Review | x | Eligible for New Business (80% or more std. met; no critical std. not met) | | 15 Locations  25 Audits |  |  |  | x | Ineligible for new business. (Deferred Status: Two year mid-cycle review License) |  | o | Ineligible for New Business (<=80% std met and/or more critical std. not met) | | Employment and Day Supports | 2 Year License |  |  | x | Eligible for new business (Two Year License) |  | o | Eligible for New Business (80% or more std. met; no critical std. not met) | | Locations   Audits |  |  |  | o | Ineligible for new business. (Deferred Status: Two year mid-cycle review License) |  | o | Ineligible for New Business (<=80% std met and/or more critical std. not met) | | |

|  |  |
| --- | --- |
|  |  |
| |  | | --- | | **Summary of Ratings** | |  |
|  |  |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | **Residential and Individual Home Supports Areas Needing Improvement on Standard not met - Identified by DDS** | | | | **Indicator #** | | L1 | | **Indicator** | | Abuse/neglect training | | **Area Need Improvement** | | Four individuals of nineteen were not aware of how to report potential abuse and neglect nor was there evidence that training had been provided to them regarding how to report potential abuse and neglect. The agency needs to ensure that all individuals are trained how to report potential abuse and neglect. | | **Status at follow-up** | | For eleven individuals the agency provided training and information on how to report potential abuse and neglect which was documented in their record. | | **#met /# rated at followup** | | 11/11 | | **Rating** | | Met | |  | | | | **Indicator #** | | L5 | | **Indicator** | | Safety Plan | | **Area Need Improvement** | | Six out of fifteen safety plans did not contain all requirement components including accurate evacuation strategies needed for all individuals residing in the home, and evidence of staff training needed for all individuals residing in the home. The agency needs to ensure that approved safety plans include all required components. | | **Status at follow-up** | | Eleven safety plans were reviewed, and staff were interviewed. The safety plans contained all the required components with specific and currently used evacuation strategies for individuals identified. Staff were knowledgeable of each individual's needed support to evacuate. | | **#met /# rated at followup** | | 11/11 | | **Rating** | | Met | |  | | | | **Indicator #** | | L22 | | **Indicator** | | Well-maintained appliances | | **Area Need Improvement** | | Five out of fourteen locations had appliances that were not operational and/or properly maintained. Issues identified included such items as excess dryer lint and kitchen appliances needing repair. The agency needs to ensure that all appliances and equipment are operational and properly maintained. | | **Status at follow-up** | | Appliances were observed to be operational and properly maintained at nine of ten locations. At one location the grill was too close to the house. Staff moved the grill to a safe location. | | **#met /# rated at followup** | | 9/10 | | **Rating** | | Met | |  | | | | **Indicator #** | | L24 | | **Indicator** | | Locked door access | | **Area Need Improvement** | | In two out of five locations, staff was not able to locate the appropriate key needed to unlock bedroom doors in the event of an emergency. The agency needs to ensure that staff are able to access individuals' bedrooms in the event of an emergency. | | **Status at follow-up** | | In three out of four homes, individuals had locks on their bedroom doors. In one location, a bedroom door did not have a lock. The agency was able to contact their maintenance department to replace the lock. Staff ensured that the newly installed lock was able to be accessed by staff with a key in the event of an emergency. | | **#met /# rated at followup** | | 3/4 | | **Rating** | | Met | |  | | | | **Indicator #** | | L35 | | **Indicator** | | Preventive screenings | | **Area Need Improvement** | | Five out of sixteen individuals had not received preventative medical screenings such as eye exams, 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 follow-up** | | Ten out of thirteen individuals had received preventative medical screenings or other recommended health screenings based on their age, history, or medical conditions. For three individuals, additional support is needed to assist them with receiving preventative medical screenings as recommended or to explore alternative options that may be less invasive. | | **#met /# rated at followup** | | 10/13 | | **Rating** | | Not Met | |  | | | | **Indicator #** | | L49 | | **Indicator** | | Informed of human rights | | **Area Need Improvement** | | The agency's grievance procedure identifies the Human Rights advocate as the person to contact to file a complaint. The information did not specify who the Human Rights Advocate was or how to contact them. The agency needs to ensure that individuals and guardians are informed of who to contact within the agency to file a grievance or express a concern about potential human rights violations. | | **Status at follow-up** | | The agency sent a copy of the grievance procedure which identified the Human Rights Officer and how to contact them to all individuals and/or their guardians. The agency utilized a database tracking system to ensure all parties received the grievance information via email or certified mail. | | **#met /# rated at followup** | | 14/14 | | **Rating** | | Met | |  | | | | **Indicator #** | | L56 | | **Indicator** | | Restrictive practices | | **Area Need Improvement** | | Restrictive practices were reviewed for six individuals. Four individuals had restrictive practices in place which did not include a written rationale or a process to fade the restriction, and/ or there was no plan to mitigate the restrictions so as to not unduly restrict the rights of others. The agency needs to ensure that restrictive practices have all required components, are reviewed as required, and include provisions so as to not unduly restrict the rights of others. | | **Status at follow-up** | | For eight individuals restrictive practices were reviewed. For five individuals all of the necessary safeguards were in place. Three of the individuals had restrictive practices in place which did not include a written rationale and/or a process to fade the restriction. The agency needs to ensure restrictive practices have all the required components. | | **#met /# rated at followup** | | 5/8 | | **Rating** | | Not Met | |  | | | | **Indicator #** | | L61 | | **Indicator** | | Health protection in ISP | | **Area Need Improvement** | | For three individuals, there was no health care provider order to outline the need and the proper use of their supports and health related protections. For one individual the proper safety checks were not occurring. The agency needs to ensure that that for all supports and health related protections there is a health care provider order that outlines the need and that all safety checks are occurring as outlined. | | **Status at follow-up** | | Two of the five individuals reviewed did not have all of the proper components present for Support and Health Related Protections. The agency needs to ensure that Support and Health Related Protections specify the device to be used, the indications for use, discontinuance, the alternatives continued, the frequency and duration of use, procedures for safety checks, and the qualified health practitioner supervising the use of the device. | | **#met /# rated at followup** | | 3/5 | | **Rating** | | Not Met | |  | | | | **Indicator #** | | L62 | | **Indicator** | | Health protection review | | **Area Need Improvement** | | For three of nine individuals, their supports and health related protections that restrict movement were not reviewed by the Human Rights Committee. The agency needs to ensure that the Human Rights Committee reviews all supports and health related protections. | | **Status at follow-up** | | For three out of five individuals supported with supports and health related protections, all of the necessary reviews were in place. For two individuals the supports in place were not reviewed by the Human Rights Committee. The agency needs to ensure that the Human Rights Committee reviews all Support and Health Related Protections. | | **#met /# rated at followup** | | 3/5 | | **Rating** | | Not Met | |  | | | | **Indicator #** | | L63 | | **Indicator** | | Med. treatment plan form | | **Area Need Improvement** | | Six out of fifteen medication treatment plans reviewed did not contain such items as listing all behavior modifying medications a person is prescribed, collecting data for review by the treating clinician to assess the efficacy of the plan or a process to reduce or eliminate the need for the medication. The agency needs to ensure that all components are present within the written plan and that data is being shared with the treating physician. | | **Status at follow-up** | | For 10 out of thirteen medication treatment plans in place, the plans contained all of the required components and data was maintained accordingly. Three of the medication treatment plans reviewed did not contain all the required components such as describing the individual's target behaviors in an observable and measurable manner and/or collecting data for review by the treating clinician. The agency needs to ensure that all components of the medication treatment plan are in the plan and that data is shared with the treating clinician. | | **#met /# rated at followup** | | 10/13 | | **Rating** | | Not Met | |  | | | | **Indicator #** | | L67 | | **Indicator** | | Money mgmt. plan | | **Area Need Improvement** | | For seven out of sixteen individuals, the money management plan did not include the level and type of staff support needed, the amount of monies that can be independently managed by individuals, a training plan when appropriate to promote independence and/or agreement to financial plans by guardians. The agency needs to ensure that money management plans include all required components including agreement by the ISP team | | **Status at follow-up** | | For six out of eleven individuals receiving placement and 24/7 residential supports, the money management plan included all of the necessary components. For five individuals, the funds management plans did not include the level and type of staff support individuals needed, the amount of monies that can be independently managed by the individual and/or a training plan when appropriate to promote independence. | | **#met /# rated at followup** | | 6/11 | | **Rating** | | Not Met | |  | | | | **Indicator #** | | L69 | | **Indicator** | | Expenditure tracking | | **Area Need Improvement** | | Expenditures were reviewed for sixteen individuals. A review of expenditure documentation for eight individuals revealed one or more of the following: missing receipts for purchases, lack of tracking of gift card purchases and lack of monitoring account balances to ensure individuals financial assets do not exceed allowable limits which could impact benefits. The agency needs to ensure individuals' expenditures are documented, tracked accurately, and that receipts are maintained in accordance with agency's financial policies. Additionally, monitoring of individual's assets needs to occur to prevent potential loss of benefits. | | **Status at follow-up** | | For ten out of fourteen individuals receiving IHS, and placement and 24/7 residential supports, funds were tracked and in accordance with the provider's policy regarding the management of individual funds. For four individuals there was one or more of the following: missing receipts for purchases, lack of monitoring account balances to ensure financial assets were accounted for, and/or did not exceed allowable limits which could impact benefits and/or incorrect balances. | | **#met /# rated at followup** | | 10/14 | | **Rating** | | Not Met | |  | | | | **Indicator #** | | L79 | | **Indicator** | | Restraint training | | **Area Need Improvement** | | In five locations, staff needed to have the requisite training to safely utilize restraint. All staff had not been trained. The agency needs to ensure that when the administration of restraint is required all staff are trained. | | **Status at follow-up** | | In one out of two locations, the number of staff trained in de-escalation techniques and restraint was not sufficient to ensure adequate coverage on all shifts. Three out of ten staff had not been trained in restraint or their training was expired. The agency needs to ensure that when the administration of restraint is potentially needed all staff are trained | | **#met /# rated at followup** | | 1/2 | | **Rating** | | Not Met | |  |  | | | **Indicator #** | | L80 | | **Indicator** | | Symptoms of illness | | **Area Need Improvement** | | At eleven of fifteen locations, staff had not been trained in a curriculum that covers the DDS Health Observation Guidelines and Just Not Right. The agency needs to ensure staff are trained to recognize signs and symptoms of illness. | | **Status at follow-up** | | Staff at twelve of twelve locations virtually visited had been trained in a curriculum that included the DDS Health Observation Guidelines and Just Not Right. | | **#met /# rated at followup** | | 12/12 | | **Rating** | | Met | |  |  | | | **Indicator #** | | L84 | | **Indicator** | | Health protect. Training | | **Area Need Improvement** | | For five of nine individuals, not all staff were trained/knowledgeable regarding the individual's supports and health related protections. The agency needs to ensure that all staff are trained and knowledgeable regarding all aspects of an individual's supports and health related protections. | | **Status at follow-up** | | For four out of five individuals, staff were trained and knowledgeable regarding the Support and Health Related Protections. For one individual, training of staff in the person's gait belt had not occurred. | | **#met /# rated at followup** | | 4/5 | | **Rating** | | Met | |  |  | | | **Indicator #** | | L86 | | **Indicator** | | Required assessments | | **Area Need Improvement** | | Required assessments for six individuals were not submitted within the required timelines. The agency needs to ensure that assessments are submitted to the DDS Area Office at least 15 days prior to the scheduled ISP meeting. | | **Status at follow-up** | | Required assessments for two individuals were submitted within the required timelines. For two individuals, this requirement was not met. The agency needs to ensure that assessments are submitted to the DDS Area Office at least 15 days prior to the scheduled ISP meeting. | | **#met /# rated at followup** | | 2/4 | | **Rating** | | Not Met | |  |  | | | **Indicator #** | | L87 | | **Indicator** | | Support strategies | | **Area Need Improvement** | | Support strategies for four individuals were not submitted within the required timelines. The agency needs to ensure that support strategies are submitted to the DDS Area Office at least 15 days prior to the scheduled ISP meeting. | | **Status at follow-up** | | Support strategies for three out of four individuals were submitted within the required timelines. | | **#met /# rated at followup** | | 3/4 | | **Rating** | | Met | |  |  | | | **Indicator #** | | L88 | | **Indicator** | | Strategies implemented | | **Area Need Improvement** | | For four individuals, the agency was not tracking progress towards ISP goals. The agency needs to ensure that services and supports identified are being implemented. | | **Status at follow-up** | | Two individuals were being supported to work towards meeting their ISP goals. For four individuals, the agency was not tracking progress toward meeting ISP goals, which included not collecting the correct data, inconsistent implementation of goals and not following teaching strategies. The agency needs to ensure that services and supports identified are being implemented as agreed to in the ISP. | | **#met /# rated at followup** | | 2/6 | | **Rating** | | Not Met | |  |  | | | **Indicator #** | | L89 | | **Indicator** | | Complaint and resolution process | | **Area Need Improvement** | | The agency's complaint resolution process had not been implemented at one location. The agency needs to ensure that the agency's complaint resolution policy and process is effectively implemented at all ABI/MFP service locations. | | **Status at follow-up** | | The agency's complaint resolution process was observed to have been implemented at the two ABI placement locations virtually visited. | | **#met /# rated at followup** | | 2/2 | | **Rating** | | Met | |  |  | | | **Indicator #** | | L91 | | **Indicator** | | Incident management | | **Area Need Improvement** | | At six out of the fifteen locations, incident reports had not been submitted and/or finalized within required timelines. The agency needs to ensure that incidents are reported and reviewed as mandated by regulation. | | **Status at follow-up** | | At five out of five locations, incident reports had been finalized and submitted within required timelines as mandated by regulation. | | **#met /# rated at followup** | | 5/5 | | **Rating** | | Met | |  |  | | | **Employment and Day Supports Areas Needing Improvement on Standard not met - Identified by DDS** |  | | | **Indicator #** | | L5 | | **Indicator** | | Safety Plan | | **Area Need Improvement** | | At one of two locations, there was not an approved safety plan in place and staff were not trained in the plan. The agency needs to ensure that safety plans are approved by the area office and that staff are trained in the implementation of the plan. | | **Status at follow-up** | |  | | **#met /# rated at followup** | |  | | **Rating** | | Not Rated | |  |  | | | **Indicator #** | | L7 | | **Indicator** | | Fire Drills | | **Area Need Improvement** | | At one of two locations, one fire drill was conducted when two were required per the safety plan. The agency needs to ensure that the minimum number of fire drills is conducted as outlined in the safety plan. | | **Status at follow-up** | |  | | **#met /# rated at followup** | |  | | **Rating** | | Not Rated | |  |  | | | **Indicator #** | | L8 | | **Indicator** | | Emergency Fact Sheets | | **Area Need Improvement** | | For three of eight individuals the emergency fact sheet did not list all of medical conditions that an emergency responder would need to know. The agency needs to ensure that all relevant medical information is documented on the emergency fact sheet.The agency needs to ensure that all significant medical information is documented on the emergency fact sheet. | | **Status at follow-up** | | This area was not evaluated as part of this review. | | **#met /# rated at followup** | |  | | **Rating** | | Not Rated | |  |  | | | **Indicator #** | | L77 | | **Indicator** | | Unique needs training | | **Area Need Improvement** | | Staff were not aware of two out of eight individual's unique medical diagnoses. The agency needs to ensure that staff are knowledgeable regarding each individual's unique needs. | | **Status at follow-up** | | This area was not evaluated as part of this review. | | **#met /# rated at followup** | |  | | **Rating** | | Not Rated | |  |  | | | **Indicator #** | | L88 | | **Indicator** | | Strategies implemented | | **Area Need Improvement** | | For two of eight individuals, data did not outline progress being made or strategies being implemented for agreed upon support strategies as outlined within the ISP. The agency needs to ensure that individuals are supported to meet their ISP objectives and it is documented in a way that clearly demonstrates efforts and outcomes of individual progress made toward achieving goals. | | **Status at follow-up** | | This area was not evaluated as part of this review. | | **#met /# rated at followup** | |  | | **Rating** | | Not Rated | |  |  | | | **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 effectively meet all of its mandated responsibilities, as there was a lack of consistent attendance from the required membership, and the HRC did not conduct an annual review of agency policies and procedures potentially impacting the rights of individuals served. The agency needs to ensure that the Human Rights committee is effective in meeting its responsibilities. | | **Status at follow-up** | | The agency's Human Rights Committee conducted a meeting virtually on 5/13/2020. The meeting had the required members present, met quorum, and reviewed the required content. The agency should conduct an annual review of agency policies and procedures potentially impacting the rights of individuals served. | | **#met /# rated at followup** | | 1/1 | | **Rating** | | Met | |  |  | | | **Indicator #** | | L65 | | **Indicator** | | Restraint report submit | | **Area Need Improvement** | | For one restraint reported, the agency did not meet the timelines for submission. The agency needs to ensure that restraint reports are submitted within required timelines. | | **Status at follow-up** | | One restraint was reported, the agency submitted it within required timelines. | | **#met /# rated at followup** | | 1/1 | | **Rating** | | Met | |  |  | | | **Indicator #** | | L74 | | **Indicator** | | Screen employees | | **Area Need Improvement** | | The agency did not have a process to ensure that required TB screenings had been completed for seven staff working with individuals receiving ABI/MFP services. The agency needs to ensure that all staff required are screened for TB. | | **Status at follow-up** | | For five staff working with individuals receiving ABI/MFP services, the agency documented that staff were screened for TB as required to work with this population. | | **#met /# rated at followup** | | 5/5 | | **Rating** | | Met | |  |  | | | **Indicator #** | | L76 | | **Indicator** | | Track trainings | | **Area Need Improvement** | | Five out of twenty staff selected did not have the required training. The agency needs to have an effective system to track and ensure staff complete all required training. | | **Status at follow-up** | | Sixteen out of seventeen staff selected had required training. Evidence of first aid training was not present for one staff. The agency will be working to ensure that staff complete all required training as required. | | **#met /# rated at followup** | | 16/17 | | **Rating** | | Met | |  |  | | | | |