|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |
| --- |
|  |

 |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| **PROVIDER REPORT FOR** |

 |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **Crystal Springs, Inc.38 Narrows Rd POB 372 Assonet, MA 02702**  |

 |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |

|  |
| --- |
|  |

 |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **Version** |

 |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |

|  |
| --- |
| **Public Provider Report** |

 |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |

|  |
| --- |
| **Prepared by the Department of Developmental ServicesOFFICE OF QUALITY ENHANCEMENT** |

 |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |

 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |

|  |
| --- |
| **SUMMARY OF OVERALL FINDINGS** |

 |  |  |
|  |  |  |  |  |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
|  |

|  |
| --- |
| **Provider** |

 |  |

|  |
| --- |
| Crystal Springs, Inc. |

 |  |  |
|  |  |  |  |  |  |
|  |

|  |
| --- |
| **Review Dates** |

 |  |

|  |
| --- |
| 5/26/2021 - 6/2/2021 |

 |  |  |
|  |  |  |  |  |  |
|  |

|  |
| --- |
| **Service Enhancement Meeting Date** |

 |  |

|  |
| --- |
| 6/16/2021 |

 |  |  |
|  |  |  |  |  |
|  |  |  |  |  |  |
|  |

|  |
| --- |
| **Survey Team** |

 |  |

|  |
| --- |
| Michelle Boyd |
| Kayla Condon (TL) |

 |  |
|  |  |  |  |
|  |  |  |  |  |  |
|  |

|  |
| --- |
| **Citizen Volunteers** |

 |  |

|  |
| --- |
|  |

 |  |  |

 |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |

|  |
| --- |
| **Survey scope and findings for Residential and Individual Home Supports** |
| **Service Group Type** | **Sample Size** | **Licensure Scope** | **Licensure Level** | **Certification Scope** | **Certification Level** |
| **Residential and Individual Home Supports** | 4 location(s) 6 audit (s)  | Full Review | 53/85 Defer Licensure  |  | 8 / 22 Certified with Progress Report  |
| Residential Services | 4 location(s) 6 audit (s)  |  |  | Full Review | 8 / 16 |
| Planning and Quality Management |   |  |  | Full Review | 0 / 6 |

 |  |

 |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **EXECUTIVE SUMMARY :** |

 |  |  |
|  |  |  |  |
|  |

|  |
| --- |
| Crystal Springs Inc. is a non-profit agency that provides services to individuals with intellectual and developmental disabilities in southeastern Massachusetts. The agency offers residential and educational options for children as well as day habilitation and 24-hour residential services to adults. Currently, 57 individuals are receiving residential services in homes located on the 45-acre campus and within typical residential communities. In 2020, a special review was conducted and after that, a Corrective Action Plan (CAP) was developed and implemented by the agency. Several reviews of the CAP implementation were conducted subsequently by the DDS. This first full review licensure and certification, subsequent to the last CAP follow up review, was conducted by the Department of Developmental Service's (DDS) Office of Quality Enhancement (OQE) of Crystal Springs' residential services. This includes a virtual review of administrative, location, and individual specific licensure and certification indicators. The review process revealed positive practices across the agency within the domain of environmental safety. Smoke alarms and carbon monoxide detectors were located where needed and were all operational. All required inspections, such as generators, furnaces, and water heaters, occurred as required. Appliances were clean and well maintained and new appliances were also present in the homes. Medication storage areas were secured and clean. Within the domain of human rights, individuals were able to visit with family within the current guidelines given by DDS due to COVID-19. Written and verbal communication was respectful of the individuals.  The survey also revealed several areas that require strengthening to meet the standards set forth in licensing indicators, in particular in the domain of health care. Oversight and case management of individuals healthcare needs strengthened systems to effectively track all healthcare practitioner recommendations and needed follow-up to ensure these are actualized for each individual. Healthcare management plans should be reviewed to ensure that all required components are present. Additionally, Aan effective mechanism need to be developed to monitor and ensure that there is staff with necessary training on all shifts. Systems for tracking and verifying that preventative care and follow-up appointments/testing is conducted in a timely manner should be enhanced to effectively identify when care has been received and what is outstanding. Special dietary needs should be implemented as outlined by the healthcare provider. In the area of medication administration, physician's orders need to be clearly written to ensure medication are administered appropriately per the Medication Administration Program (MAP) guidelines. Assisting individuals with the management of their funds also requires additional oversight. Efforts are needed to ensure when the agency has shared and/or delegated funds management with individuals, that support plans are developed that there are tracking mechanism or expenditures, and that tracking of funds received and expended includes funds held in all accounts for the person and cash on hand at their home. The audits of individual funds completed by Residential Directors were not completed accurately and there was no evidence provided that demonstrated that quarterly audits completed by the business office were completed. In 2020, the DDS Bureau of integrity recommended, that CSI ensure the performance of monthly audits by Residential Supervisors and quarterly audits by Business Office personnel, however this was not fully implemented. Additional efforts should be made to work with Representative Payees to determine if protected savings accounts could benefit individuals who have sums of money accumulated that could affect their benefits.Within the domain of human rights, data that is collected for Positive Behavioral Plans needs to be specific and completed as outlined within the plan. For individuals that are identified to be at risk, interventions to reduce risk need to be implemented as outlined. When environmental restrictions are in place within the home there must be a written rationale and mitigating factors implement to not unduly restrict the rights of others.In the area of supervision and oversight, additional efforts are needed to ensure concerns in the provision of services are addressed in an efficient and timely manner. A system should be in place to verify that issues identified are fully resolved. In particular, areas that need strengthening include ensuring that the audits of individual funds management is accurate, support plans to address health and clinical needs are comprehensive and at each home there is adequate number of staff with necessary training on each shift.Additional efforts need to be made to support the individuals to maintain friendships including the use of current technology to stay connected. A focus should also occur on ways to maximize each individual's independence. This includes ensuring individuals are involved in typical activities/routines and exploring assistive technology that may enable individuals to complete tasks independently without staff assistance. Another area of focus should be assisting individuals to explore potential wants related to intimacy and companionship.Organizationally, the agency needs to strengthen its quality assurance systems to ensure that that these are measuring the presence of expected outcomes. Many of the mechanisms in place consist of collecting data that does not correlate to the identified benchmarks. Additionally, mechanisms that did show when an outcome was not present, such as the need for individuals to receive follow up medical care, issues were not addressed in a timely manner or not at all. The license level for residential services is deferred because of receiving a not met in two critical indicators and receiving an overall less than 80% met in the licensing indicators. This status will remain pending the results of a follow-up review which will occur within 60 days. The agency is Certified with a Progress Report with 36% of the certification indicators receiving a rating of Met. The agency will have one year to address the certification findings and prepare its progress report on the certification indicators that were rated Not Met. |

 |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
|

|  |
| --- |
| **LICENSURE FINDINGS** |

 |  |  |
|  |  |  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Met / Rated** | **Not Met / Rated** | **% Met** |
| **Organizational** | **7/10** | **3/10** |  |
| **Residential and Individual Home Supports** | **46/75** | **29/75** |  |
|  Residential Services |  |  |  |
| **Critical Indicators** | **6/8** | **2/8** |  |
| **Total** | **53/85** | **32/85** | **62%** |
| **Defer Licensure** |  |  |  |
| **# indicators for 60 Day Follow-up** |  | **32** |  |

 |  |
|  |  |  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | **Organizational Areas Needing Improvement on Standards not met/Follow-up to occur:** |
|  | **Indicator #** | **Indicator** | **Area Needing Improvement** |
|  |  L48 | The agency has an effective Human Rights Committee. | The Human Rights Committee (HRC) was not comprised of members with the required medical/nursing expertise. The agency needs to ensure that HRC meets all the membership requirements. |
|  |  L65 | Restraint reports are submitted within required timelines. | Of the seven restraints reviewed, all were not finalized within the required five-day timeline. The agency needs to ensure that all restraint reports are finalized within the required timelines. |
|  |  L74 | The agency screens prospective employees per requirements. | Of the eight staff reviewed two staff did not meet the minimum education requirements identified in the agency's job description for the position for program director. The agency needs to ensure that prospective employees are screened based on the job description for the position. |

 |

 |  |
|  |  |  |
|  |

|  |
| --- |
|  |
|

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  | **Residential Areas Needing Improvement on Standards not met/Follow-up to occur:** |
|  | **Indicator #** | **Indicator** | **Area Needing Improvement** |
|  |  L1 | Individuals have been trained and guardians are provided with information in how to report alleged abuse/neglect. | Two individuals, and their guardian had not received information on how to report abuse, neglect, or mistreatment. The agency needs to ensure that there is a mechanism in place to track and/or identify which guardians were sent information. |
|  |  L5 | There is an approved safety plan in home and work locations.  | Of the four locations reviewed, two locations did not have an approved safety plan in place. At one location supports and health related protective equipment were not used for evacuation as outlined in the Safety Plan. They agency needs to ensure that all safety plans are approved and that evacuation procedures are being implemented as outlined within the plan. |
|  |  L10 | The provider implements interventions to reduce risk for individuals whose behaviors may pose a risk to themselves or others.  | For three individuals, environmental sweeps necessary to reduce the risk associated with having PICA, were not occurring as outlined in their behavior support plan. The agency needs to ensure that support strategies related to risk are implemented as outlined for each individual. |
|  |  L24 | Locks on doors not providing egress can be opened by the individuals from the inside and staff carry a key to open in an emergency. | At two of the four locations reviewed keys were not readily available to unlock doors in the event of an emergency. The agency needs to ensure that for all doors that have locks, the keys are present, and staff are aware of their location. |
|  |  L34 | Individuals receive an annual dental exam.  | Five of six individuals were not supported to receive an annual dental exam or assist with scheduling an appointment. The agency needs to ensure all individuals are supported to receive an annual dental exam. |
|  |  L35 | Individuals receive routine preventive screenings.  | Four of the six individuals reviewed were not supported to receive preventative screenings. This included hearing tests, eye exams, and bone density scans. The agency needs to ensure that all preventive care recommend on the DDS Adult Screening Recommendations tool are discussed with the health care provided and followed-up on. |
|  |  L36 | Recommended tests and appointments with specialists are made and kept.  | Support was not provided for individuals to attend appointments with specialist for four of the six individuals reviewed. Various follow-up appointments with dermatology, hematology, audiology, and ophthalmology did not occur when requested. For one individual a follow-up scan was not conducted as requested. The agency needs to ensure that all recommended tests and appointments with specialist are made and kept. |
| O |  L38 | Physicians' orders and treatment protocols are followed (when agreement for treatment has been reached by the individual/guardian/team).  | Six health care management plans were reviewed. Some health care management plans did not address when the health care provider should be contacted. Additionally, there was an insufficient number of staff on shift trained in the health care management plans. The agency needs to ensure all healthcare management plans include criteria for when to contact the health care provider as well as have a sufficient number of staff trained on each shift. |
|  |  L39 | Special dietary requirements are followed.  | Three of the six individuals reviewed did not have their special dietary needs meet. In two cases caloric intake and/or sodium intake was not being tracked for individuals to determine if they were being supported to follow recommendations. For another individual menus and food in the home did not align with his low cholesterol diet. The agency needs to ensure that unique dietary needs are met. |
|  |  L41 | Individuals are supported to follow a healthy diet. | At two homes, the food present in was highly processed and did not consist of ample fresh and heathy offerings. The agency needs to ensure that foods available are balanced and nutritious. |
|  |  L43 | The health care record is maintained and updated as required.  | The health care record for two individuals did not include all their medical diagnoses. The agency needs to ensure that health care records are up to date and include all diagnoses. |
| O |  L46 |  All prescription medications are administered according to the written order of a practitioner and are properly documented on a Medication Treatment Chart.  | A medication review for two individuals identified bowel movement tracking was inconsistent. As a result, there were inconsistencies in the medication being administered properly. Additionally, a medication was not administered according to the physician's orders and was administration times were not clarified the physician in a timely manner. The agency needs to ensure parameters for administering medications are implemented correctly and all medications are administered according to the physician's orders. |
|  |  L49 | Individuals and guardians have been informed of their human rights and know how to file a grievance or to whom they should talk if they have a concern. | For three individuals, information on human rights how to file a grievance was not provided to them and their guardians. The agency needs to ensure that there is a mechanism in place to track and/or identify which guardians were sent information and ensure all individuals are trained regarding their human rights and how to file a grievance. |
|  |  L56 | Restrictive practices intended for one individual that affect all individuals served at a location need to have a written rationale that is reviewed as required and have provisions so as not to unduly restrict the rights of others. | For five individuals' environmental restrictions were present in the home. In two instances mitigation plans were not in place to not unduly restrict the rights of others. In three instances, there was no written rationale for the use of the environmental restrictions. Guardians were not made aware of these restrictions. The agency needs to ensure that all environmental restrictions have a written rationale, a mitigation plan, and that guardians are informed of any environmental restrictions are in place. |
|  |  L60 | Data are consistently maintained and used to determine the efficacy of behavioral interventions. | In two locations, data tracking on the observation of targeted behaviors identified in the behavior support plans was not occurring. The agency needs to ensure data is tracked for all behaviors identified in the behavior support plans. |
|  |  L61 | Supports and health related protections are included in ISP assessments and the continued need is outlined. | The review of health-related supports and protective equipment, showed a lack of strategies to ensure proper cleaning and care for the devices for two individuals. Also, safety checks of the devices are not occurring. The agency needs to ensure there are strategies in place for cleaning/care and safety checks for the device. |
|  |  L63 | Medication treatment plans are in written format with required components. | Four of the medication treatment plans did not include all of the required components. The medication treatment plans lacked specific symptoms/ behaviors to be modified, adequate tracking of behaviors, and clinical indications for terminating the medications. The agency needs to ensure medication treatment plans are written to all required components. |
|  |  L67 | There is a written plan in place accompanied by a training plan when the agency has shared or delegated money management responsibility. | For two of the six individuals, a money management support plan was not in place. The agency needs to ensure that money management support plans are in place when the agency hold funds on behalf of an individual. |
|  |  L69 | Individual expenditures are documented and tracked. | The review of funds management for individuals, showed a lack of tracking/ documentation of funds withdrawn from the individual's funds kept in their home and community bank account. A review of assets indicted that individuals have not been supported to protect their financial assets or reoccurring benefits. The agency needs to ensure a tracking of all expenditures are documented and individuals are supported to protect their financial assets or reoccurring benefits. |
|  |  L71 | Individuals are notified of their appeal rights for their charges for care. | The charges for care letters did not include contact information for whom to dispute charges to. The agency needs to ensure that individuals/guardians are aware of whom to dispute a charge to. |
|  |  L77 | The agency assures that staff / care providers are familiar with and trained to support the unique needs of individuals. | Staff have not been provided training on the individuals' unique needs related to recommended diets, their medical and clinical diagnoses and implementation of health management plans and supports and health related protective equipment. The agency needs to ensure staff have been trained on individuals unique needs. |
|  |  L78 | Staff are trained to safely and consistently implement restrictive interventions. | For two locations, environmental restrictions were in place and there was an insufficient number of staff trained on how to properly implement the restrictions. The agency needs to ensure that staff are trained in all environmental restrictions and that staffing patterns reflect trained staff on all shifts. |
|  |  L84 | Staff / care providers are trained in the correct utilization of health related protections per regulation. | For four individuals an adequate number of staff were not trained in the individual's health related supports and protective equipment. For one individual staff were not applying the protective equipment as outlined by the prescriber. The agency needs to ensure that staff are trained and knowledgeable regarding individuals' health related supports and protective equipment. |
|  |  L85 | The agency provides ongoing supervision, oversight and staff development. | At four locations, there is a lack of oversight and supervision regarding the individuals' financial, medical, clinical and/or medication administration needs. The agency needs to ensure there is oversight and supervision of individual's needs and finances. |
|  |  L86 | Required assessments concerning individual needs and abilities are completed in preparation for the ISP. | ISP assessments were not submitted on time. The agency needs to ensure that all ISP assessments are submitted 15 days prior to the ISP. |
|  |  L87 | Support strategies necessary to assist an individual to meet their goals and objectives are completed and submitted as part of the ISP. | Support strategies necessary to assist an individual to meet their goals and objectives are completed and submitted as part of the ISP. Support strategies were not submitted on time. The agency needs to ensure that all support strategies are submitted 15 days prior to the ISP. |
|  |  L88 | Services and support strategies identified and agreed upon in the ISP for which the provider has designated responsibility are being implemented. | Four individuals have not been supported to implement services and support strategies as identified in the ISP. The agency needs to ensure services and support strategies are implemented as identified in the ISP. |
|  |  L90 | Individuals are able to have privacy in their own personal space. | Two individuals were not afforded privacy in their bedrooms. One bedroom did not have a lock. Another individual is sharing a bedroom and privacy screens are not in place. The agency needs to ensure that individuals are able to have privacy in their bedrooms. |
|  |  L91 | Incidents are reported and reviewed as mandated by regulation. | For two locations incidents were not reported via the HCSIS. At one location an incident was finalized after the required timelines. The agency needs to ensure that all incidents are reported in HCSIS and are finalized within the required timelines. |

 |
|  |

 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |

|  |
| --- |
| **CERTIFICATION FINDINGS** |

 |  |  |
|  |  |  |  |  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Met / Rated** | **Not Met / Rated** | **% Met** |
| **Certification - Planning and Quality Management** | **0/6** | **6/6** |  |
| **Residential and Individual Home Supports** | **8/16** | **8/16** |  |
| Residential Services | 8/16 | 8/16 |  |
| **TOTAL** | **8/22** | **14/22** | **36%** |
| **Certified with Progress Report** |  |  |  |

 |  |  |  |
|  |  |  |  |  |
|  |

|  |  |
| --- | --- |
|  | **Planning and Quality Management Areas Needing Improvement on Standards not met:** |
|  | **Indicator #** | **Indicator** | **Area Needing Improvement** |
|  |  C1 | The provider collects data regarding program quality including but not limited to incidents, investigations, restraints, and medication occurrences. | The agency did not have effective mechanisms to collect data on programmatic areas of concern or on the presence of desired outcomes which is necessary to successfully identify patterns and trend. The agency needs to collect data regarding program quality including but not limited to incidents, investigations, restraints, and medication occurrences. |
|  |  C2 | The provider analyzes information gathered from all sources and identifies patterns and trends. | As the data collected in some areas was about the presence of a document versus meeting an outcome (e.g. presence of physician's orders versus are medications administered properly and in several areas, the data was inaccurate, the agency does not have effective strategies to identify the need for corrective action or changes in service provision. The agency needs to gather outcome-based information and identify patterns and trends. |
|  |  C3 | The provider actively solicits and utilizes input from the individuals and families regarding satisfaction with services. | The agency conducted satisfaction surveys and tabulated results. Two areas were targeted to be addressed; one was to enhance communication with families. The second highest complaint was not used for developing changes in services. The issue with the most concern by parents/guardians, was the lack of sufficient community outings (5 out of 17 responses) and individuals indicated that they could not choose what they eat (this area and community access were areas that individuals had any negative response). The provider needs to utilize feedback from families and guardians. |
|  |  C4 | The provider receives and utilizes input received from DDS and other stakeholders to inform service improvement efforts. | Service improvement efforts have not been put in place to address concerns and expectations set forth by the DDS and CMS. The agency needs to enhance its efforts to improve the quality of services at the meet the outcomes expected by the DDS and CMS. |
|  |  C5 | The provider has a process to measure progress towards achieving service improvement goals. | The mechanisms in place to measure progress towards achieving service improvement goals did not fully determine if outcomes were achieved. Additionally, when issues regarding service quality were identified corrective action was not taken in a timely manner or not completed. |
|  |  C6 | The provider has mechanisms to plan for future directions in service delivery and implements strategies to actualize these plans. | The agency identified that its strategic plan was not being implemented during the COVID-19 emergency, however there were goals identified in the plan that included the provision of services that should have been afforded to individuals each day in areas such as choice and control over meal choices, involvement in evaluations of their staff, and choices for meaningful leisure activities. It is anticipated that as the state of emergency is lifted that other areas of the strategic plan can be implemented. |
|  |  |  |  |

 |  |
|  |  |  |  |  |
|  |

|  |  |
| --- | --- |
|  | **Residential Services- Areas Needing Improvement on Standards not met:** |
|  | **Indicator #** | **Indicator** | **Area Needing Improvement** |
|  |  C7 | Individuals have opportunities to provide feedback at the time of hire / time of the match and on an ongoing basis on the performance/actions of staff / care providers that support them. | Three individuals of the six were not afforded the opportunity to provide feedback regarding the staff that support them. The agency needs to ensure that individuals are afforded this opportunity. |
|  |  C11 | Staff (Home Providers) support individuals to get together with families and friends. | Two of the six individuals, were not supported to maintain relationships with friends. The agency needs to ensure that individuals are supported to maintain relationships via various modalities. |
|  |  C12 | Individuals are supported to explore, define, and express their need for intimacy and companionship. | Five of six individuals have not been supported to explore their needs for intimacy and companionship. The agency needs to support individuals in identifying their needs for intimacy and companionship as well as explore those interests once identified. |
|  |  C13 | Staff (Home Providers) provide support for individuals to develop skills to enable them to maximize independence and participation in typical activities and routines.  | Two individuals have not been supported to actively participate in daily home activities to maximize their independence and participation in typical activities. The agency needs to support individuals to engage in daily activities to maximize their independence and participation in typical activities. |
|  |  C15 | Staff (Home Providers) support individuals to personalize and decorate their rooms/homes and personalize common areas according to their tastes and preferences. | At two locations, individuals' bedrooms were not personalized. The agency needs to ensure that individuals are supported to personalize and decorate their bedrooms based on their interests and preferences. |
|  |  C18 | Staff (Home Providers) assist individual to purchase personal belongings.  | Three individuals had limited opportunities to purchase personal belongings. The agency needs to ensure that individuals are supported to select and purchase their own belongings and explore alternative methods such as on-line when necessary. |
|  |  C49 | The physical setting blends in with and is a natural part of the neighborhood and community. | Two of the homes are located on a campus setting. A third home is located across from the campus but has a parking lot in the front of the home. The agency needs to ensure that homes blend in with and are a natural part of the neighborhood and community |
|  |  C54 | Individuals have the assistive technology and/or modifications to maximize independence.  | Six individuals were not supported to use assistive technology to maximize their independence. According to assessments completed potential AT individuals could benefit from include adaptive clothing, sequencing charts, adapted remotes and light switches, as well as various low-tech supports. The agency needs to ensure that when an individual had an identified area where they need staff support, that assistive technology is explored to see if could increase the individual's independence. |
|  |  |  |  |

 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |

|  |
| --- |
| **MASTER SCORE SHEET LICENSURE** |

 |  |  |  |
|  |  |  |  |  |
|  |

|  |
| --- |
| **Organizational: Crystal Springs, Inc.** |

 |  |  |  |
|  |  |  |  |  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Indicator #** | **Indicator** | **Met/Rated** | **Rating(Met,Not Met,NotRated)** |
| O |  L2 | Abuse/neglect reporting | **3/4** | **Met(75.00 % )** |
|  |  L3 | Immediate Action | **15/15** | **Met** |
|  |  L4 | Action taken | **13/15** | **Met(86.67 % )** |
|  |  L48 | HRC | **0/1** | **Not Met(0 % )** |
|  |  L65 | Restraint report submit | **0/7** | **Not Met(0 % )** |
|  |  L66 | HRC restraint review | **7/7** | **Met** |
|  |  L74 | Screen employees | **6/8** | **Not Met(75.00 % )** |
|  |  L75 | Qualified staff | **2/2** | **Met** |
|  |  L76 | Track trainings | **10/12** | **Met(83.33 % )** |
|  |  L83 | HR training | **12/12** | **Met** |

 |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
|  |

|  |
| --- |
| **Residential and Individual Home Supports:** |

 |  |  |  |  |
|  |  |  |  |  |  |
|  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Ind. #** | **Ind.** | **Loc. or Indiv.** | **Res. Sup.** | **Ind. Home Sup.** | **Place.** | **Resp.** | **ABI-MFP Res. Sup.** | **ABI-MFP Place.** | **Total Met/Rated** | **Rating** |
|  |  L1 | Abuse/neglect training | I | 4/6 |  |  |  |  |  | **4/6** | **Not Met(66.67 %)** |
|  |  L5 | Safety Plan | L | 2/4 |  |  |  |  |  | **2/4** | **Not Met(50.0 %)** |
| O |  L6 | Evacuation | L | 3/4 |  |  |  |  |  | **3/4** | **Met** |
|  |  L7 | Fire Drills | L | 3/4 |  |  |  |  |  | **3/4** | **Met** |
|  |  L8 | Emergency Fact Sheets | I | 5/6 |  |  |  |  |  | **5/6** | **Met(83.33 %)** |
|  |  L9 | Safe use of equipment | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L10 | Reduce risk interventions | I | 2/5 |  |  |  |  |  | **2/5** | **Not Met(40.0 %)** |
| O |  L11 | Required inspections | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
| O |  L12 | Smoke detectors | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
| O |  L13 | Clean location | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L14 | Site in good repair | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L15 | Hot water | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L16 | Accessibility | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L17 | Egress at grade  | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L18 | Above grade egress | L | 2/2 |  |  |  |  |  | **2/2** | **Met** |
|  |  L19 | Bedroom location | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L20 | Exit doors | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L21 | Safe electrical equipment | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L22 | Well-maintained appliances | L | 3/4 |  |  |  |  |  | **3/4** | **Met** |
|  |  L24 | Locked door access | L | 2/4 |  |  |  |  |  | **2/4** | **Not Met(50.0 %)** |
|  |  L25 | Dangerous substances | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L26 | Walkway safety | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L27 | Pools, hot tubs, etc. | L | 3/4 |  |  |  |  |  | **3/4** | **Met** |
|  |  L28 | Flammables | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L29 | Rubbish/combustibles | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L30 | Protective railings | L | 3/3 |  |  |  |  |  | **3/3** | **Met** |
|  |  L31 | Communication method | I | 5/6 |  |  |  |  |  | **5/6** | **Met(83.33 %)** |
|  |  L32 | Verbal & written | I | 6/6 |  |  |  |  |  | **6/6** | **Met** |
|  |  L33 | Physical exam | I | 6/6 |  |  |  |  |  | **6/6** | **Met** |
|  |  L34 | Dental exam | I | 1/6 |  |  |  |  |  | **1/6** | **Not Met(16.67 %)** |
|  |  L35 | Preventive screenings | I | 2/6 |  |  |  |  |  | **2/6** | **Not Met(33.33 %)** |
|  |  L36 | Recommended tests | I | 2/6 |  |  |  |  |  | **2/6** | **Not Met(33.33 %)** |
|  |  L37 | Prompt treatment | I | 5/6 |  |  |  |  |  | **5/6** | **Met(83.33 %)** |
| O |  L38 | Physician's orders | I | 0/6 |  |  |  |  |  | **0/6** | **Not Met(0 %)** |
|  |  L39 | Dietary requirements | I | 3/6 |  |  |  |  |  | **3/6** | **Not Met(50.0 %)** |
|  |  L40 | Nutritional food | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L41 | Healthy diet | L | 2/4 |  |  |  |  |  | **2/4** | **Not Met(50.0 %)** |
|  |  L42 | Physical activity | L | 3/4 |  |  |  |  |  | **3/4** | **Met** |
|  |  L43 | Health Care Record | I | 4/6 |  |  |  |  |  | **4/6** | **Not Met(66.67 %)** |
|  |  L44 | MAP registration | L | 3/3 |  |  |  |  |  | **3/3** | **Met** |
|  |  L45 | Medication storage | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
| O |  L46 | Med. Administration | I | 4/6 |  |  |  |  |  | **4/6** | **Not Met(66.67 %)** |
|  |  L49 | Informed of human rights | I | 3/6 |  |  |  |  |  | **3/6** | **Not Met(50.0 %)** |
|  |  L50 | Respectful Comm. | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L51 | Possessions | I | 5/6 |  |  |  |  |  | **5/6** | **Met(83.33 %)** |
|  |  L52 | Phone calls | I | 5/6 |  |  |  |  |  | **5/6** | **Met(83.33 %)** |
|  |  L53 | Visitation | I | 6/6 |  |  |  |  |  | **6/6** | **Met** |
|  |  L54 | Privacy | L | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L55 | Informed consent | I | 2/2 |  |  |  |  |  | **2/2** | **Met** |
|  |  L56 | Restrictive practices | I | 0/5 |  |  |  |  |  | **0/5** | **Not Met(0 %)** |
|  |  L57 | Written behavior plans | I | 4/4 |  |  |  |  |  | **4/4** | **Met** |
|  |  L59 | Behavior plan review | I | 1/1 |  |  |  |  |  | **1/1** | **Met** |
|  |  L60 | Data maintenance | I | 2/4 |  |  |  |  |  | **2/4** | **Not Met(50.0 %)** |
|  |  L61 | Health protection in ISP | I | 4/6 |  |  |  |  |  | **4/6** | **Not Met(66.67 %)** |
|  |  L62 | Health protection review | I | 6/6 |  |  |  |  |  | **6/6** | **Met** |
|  |  L63 | Med. treatment plan form | I | 2/6 |  |  |  |  |  | **2/6** | **Not Met(33.33 %)** |
|  |  L64 | Med. treatment plan rev. | I | 5/6 |  |  |  |  |  | **5/6** | **Met(83.33 %)** |
|  |  L67 | Money mgmt. plan | I | 4/6 |  |  |  |  |  | **4/6** | **Not Met(66.67 %)** |
|  |  L68 | Funds expenditure | I | 5/6 |  |  |  |  |  | **5/6** | **Met(83.33 %)** |
|  |  L69 | Expenditure tracking | I | 2/6 |  |  |  |  |  | **2/6** | **Not Met(33.33 %)** |
|  |  L70 | Charges for care calc. | I | 5/6 |  |  |  |  |  | **5/6** | **Met(83.33 %)** |
|  |  L71 | Charges for care appeal | I | 0/6 |  |  |  |  |  | **0/6** | **Not Met(0 %)** |
|  |  L77 | Unique needs training | I | 2/6 |  |  |  |  |  | **2/6** | **Not Met(33.33 %)** |
|  |  L78 | Restrictive Int. Training | L | 2/4 |  |  |  |  |  | **2/4** | **Not Met(50.0 %)** |
|  |  L79 | Restraint training | L | 2/2 |  |  |  |  |  | **2/2** | **Met** |
|  |  L80 | Symptoms of illness | L | 3/4 |  |  |  |  |  | **3/4** | **Met** |
|  |  L81 | Medical emergency | L | 3/4 |  |  |  |  |  | **3/4** | **Met** |
| O |  L82 | Medication admin. | L | 3/4 |  |  |  |  |  | **3/4** | **Met** |
|  |  L84 | Health protect. Training | I | 2/6 |  |  |  |  |  | **2/6** | **Not Met(33.33 %)** |
|  |  L85 | Supervision  | L | 0/4 |  |  |  |  |  | **0/4** | **Not Met(0 %)** |
|  |  L86 | Required assessments | I | 1/2 |  |  |  |  |  | **1/2** | **Not Met(50.0 %)** |
|  |  L87 | Support strategies | I | 1/3 |  |  |  |  |  | **1/3** | **Not Met(33.33 %)** |
|  |  L88 | Strategies implemented | I | 2/6 |  |  |  |  |  | **2/6** | **Not Met(33.33 %)** |
|  |  L90 | Personal space/ bedroom privacy | I | 4/6 |  |  |  |  |  | **4/6** | **Not Met(66.67 %)** |
|  |  L91 | Incident management | L | 1/4 |  |  |  |  |  | **1/4** | **Not Met(25.00 %)** |
|  | **#Std. Met/# 75 Indicator** |  |  |  |  |  |  |  |  | **46/75** |  |
|  | **Total Score** |  |  |  |  |  |  |  |  | **53/85** |  |
|  |  |  |  |  |  |  |  |  |  | **62.35%** |  |

 |  |  |  |  |
|  |  |  |  |  |  |
|  |

|  |
| --- |
| **MASTER SCORE SHEET CERTIFICATION** |

 |  |  |  |  |
|  |  |  |  |  |  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Certification - Planning and Quality Management** |  |  |  |
|  | **Indicator #** | **Indicator** | **Met/Rated** | **Rating** |
|  |  C1 | Provider data collection | 0/1 | **Not Met (0 %)** |
|  |  C2 | Data analysis | 0/1 | **Not Met (0 %)** |
|  |  C3 | Service satisfaction | 0/1 | **Not Met (0 %)** |
|  |  C4 | Utilizes input from stakeholders | 0/1 | **Not Met (0 %)** |
|  |  C5 | Measure progress | 0/1 | **Not Met (0 %)** |
|  |  C6 | Future directions planning | 0/1 | **Not Met (0 %)** |
|  |  |  |  |  |

 |  |  |  |  |
|  |  |  |  |  |  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Residential Services** |  |  |  |
| **Indicator #** | **Indicator** | **Met/Rated** | **Rating** |
|  C7 | Feedback on staff / care provider performance | 3/6 | **Not Met (50.0 %)** |
|  C8 | Family/guardian communication | 6/6 | **Met** |
|  C10 | Social skill development | 6/6 | **Met** |
|  C11 | Get together w/family & friends | 4/6 | **Not Met (66.67 %)** |
|  C12 | Intimacy | 1/6 | **Not Met (16.67 %)** |
|  C13 | Skills to maximize independence  | 4/6 | **Not Met (66.67 %)** |
|  C14 | Choices in routines & schedules | 6/6 | **Met** |
|  C15 | Personalize living space | 2/4 | **Not Met (50.0 %)** |
|  C18 | Purchase personal belongings | 3/6 | **Not Met (50.0 %)** |
|  C19 | Knowledgeable decisions | 6/6 | **Met** |
|  C20 | Emergency back-up plans | 4/4 | **Met** |
|  C49 | Physical setting is consistent  | 1/4 | **Not Met (25.00 %)** |
|  C51 | Ongoing satisfaction with services/ supports | 6/6 | **Met** |
|  C52 | Leisure activities and free-time choices /control | 5/6 | **Met (83.33 %)** |
|  C53 | Food/ dining choices | 4/5 | **Met (80.0 %)** |
|  C54 | Assistive technology | 0/6 | **Not Met (0 %)** |
|  |  |  |  |

 |  |  |  |  |