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| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Provider | ELIOT COMMUNITY HUMAN SERVICES |  | Provider Address | 125 Hartwell Ave , Lexington | | Survey Team | Downing, John; Caccioppoli, Meagan; Dolan, Cheryl; Hazelton, John; |  | Date(s) of Review | 07-OCT-21 to 14-OCT-21 | |
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| |  | | --- | |  | | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **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 | Defer Licensure |  | 10/17 | 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) | | 7 Locations  19 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 |  | 6/6 | x | Eligible for new business (Two Year License) | 2 Year License | x | Eligible for New Business (80% or more std. met; no critical std. not met) | | 2 Locations  7 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) | | |

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At one location only half of the staff were knowledgeable in the implementation strategies outlined in the safety plan. The agency needs to ensure that all safety plans have all required components and all staff are trained. | | **Status at follow-up** | For both locations, safety plans were current, and staff had been trained in their correct implementation. | | **#met /# rated at followup** | 2/2 | | **Rating** | Met | |  | | | **Indicator #** | L7 | | **Indicator** | Fire Drills | | **Area Need Improvement** | At one of two homes, staff were not conducting fire drills with the required minimum staff ratio. The agency needs to ensure that fire drills are being conducted as outline in the safety plan. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L8 | | **Indicator** | Emergency Fact Sheets | | **Area Need Improvement** | Four out of the eleven emergency fact sheets did not contain accurate information, including a diagnoses and guardianship status. The agency needs to ensure emergency fact sheets are up to date with accurate information. | | **Status at follow-up** | For eight of nine individuals, emergency fact sheets had been updated to include accurate and relevant information. | | **#met /# rated at followup** | 8/9 | | **Rating** | Met | |  | | | **Indicator #** | L10 | | **Indicator** | Reduce risk interventions | | **Area Need Improvement** | For two of four individuals, interventions to reduce risk were not being implemented. One individual utilizes equipment to reduce the likelihood of falls. Staff were not aware of where this equipment was or how to use it. Another individual was being left in the community, despite requiring supervision. The agency needs to ensure that staff are knowledgeable on how to support the individuals who are at risk and implement required staffing patterns and interventions designed to mitigate risk. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L12 | | **Indicator** | Smoke detectors | | **Area Need Improvement** | Two of the six homes did not have smoke and carbon monoxide detectors located where required or were not operational. The agency needs to ensure smoke and carbon monoxide and smoke detectors are located where required and are operational. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L13 | | **Indicator** | Clean location | | **Area Need Improvement** | Two of six locations were not clean and/or free of insect infestation. The agency needs to ensure all locations are clean and/or free of an infestation. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L15 | | **Indicator** | Hot water | | **Area Need Improvement** | At three of the six homes water temperatures did not test within the required range. The agency needs to ensure water temperatures test between 110 and 120 degrees. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L17 | | **Indicator** | Egress at grade | | **Area Need Improvement** | Two out of six homes had a second means of egress on the ground floor that individuals were not able to use. The agency needs to ensure that at each home, egresses at grade can be easily opened by individuals without the use of a key. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L23 | | **Indicator** | Egress door locks | | **Area Need Improvement** | One home had locks on two bedroom doors that provided means of egress. The agency needs to ensure that no bedrooms providing egress have locks. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L24 | | **Indicator** | Locked door access | | **Area Need Improvement** | At one of two homes the keys to bedroom doors were not carried by staff and/or could not be easily found. The agency needs to ensure that keys to bedroom doors are quickly accessible by staff and all staff are aware of their location for emergency purposes. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L27 | | **Indicator** | Pools, hot tubs, etc. | | **Area Need Improvement** | In two homes with swimming pools, individuals had not been assessed for their water safety skills. The agency needs to assess individuals for their skills related to water safety and determine the level of support they each need. The agency needs to ensure that staff and care providers provide the level of support each individual's needs based on the completed assessment. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L35 | | **Indicator** | Preventive screenings | | **Area Need Improvement** | Three out of eleven individuals had not received preventative medical screenings such as a colonoscopy, 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** | All individuals for whom medical care was provided by the agency had received routine preventive screenings. | | **#met /# rated at followup** | 6/6 | | **Rating** | Met | |  | | | **Indicator #** | L36 | | **Indicator** | Recommended tests | | **Area Need Improvement** | Three out of eleven individuals had not received recommended tests or appointments with specialists. The agency needs to ensure recommended tests and appointments with specialists occur. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L38 | | **Indicator** | Physician's orders | | **Area Need Improvement** | Four out of nine individuals with significant diagnosis requiring ongoing management by a health care professional did not have treatment protocols in place. Two out of nine individuals had treatment protocols which lacked required components such as signs and symptoms specific to that individual or instructions on use and cleaning of medically necessary equipment. The agency needs to ensure that individuals with significant medical conditions that require ongoing management have medical / health care treatment protocols in place with all required components. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L43 | | **Indicator** | Health Care Record | | **Area Need Improvement** | Health care records for six of eleven people were not accurate. The health care records reviewed were missing diagnoses, dietary needs, allergies, and health related protections. The agency needs to ensure that health care records are accurate and maintained. | | **Status at follow-up** | Health Care Records were updated for all individuals for whom the agency provided medical oversight. | | **#met /# rated at followup** | 6/6 | | **Rating** | Met | |  | | | **Indicator #** | L46 | | **Indicator** | Med. Administration | | **Area Need Improvement** | Of ten individuals, medications were not properly administered for four. For several, medications orders were either expired or not present. Additionally, orders were not always clear which lead to confusion regarding which medications to give. The agency needs to ensure that all medications are administered accurately. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L47 | | **Indicator** | Self medication | | **Area Need Improvement** | One individual who administers his medication did not meet the criteria to be self-medicating based on his assessment. The agency needs to ensure individuals are provided the necessary support to safely administer medication. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L56 | | **Indicator** | Restrictive practices | | **Area Need Improvement** | A restrictive practice was being implemented for one individual without a plan to fade or eliminate the practice. This plan had not been reviewed by the Human Rights Committee. The agency needs to ensure that restrictive practices include all required components and undergo all required reviews. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L57 | | **Indicator** | Written behavior plans | | **Area Need Improvement** | For two individuals at one location, the house practice of implementing a 9pm "bed time" and utilizing time-out for swearing was being utilized. There was no written plan to rationalize the need for these restrictions for either person. The agency needs to ensure that all practices that limit an individual's rights are only developed and implemented in accordance with individuals' needs and then are outlined within a written plan. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L58 | | **Indicator** | Behavior plan component | | **Area Need Improvement** | For two individuals the practice of implementing a 9pm "bed time" and utilizing time-out for swearing was being utilized. Neither individual had a written plan identifying behaviors for modification, and the rationale for t these restrictions as the least restrictive for the person. The agency needs to ensure that all practices that limit an individual's rights are originated from an individualized need, are in a written form and contain data, justification as the least restrictive and plans to fade when behavioral shaping has occurred. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L59 | | **Indicator** | Behavior plan review | | **Area Need Improvement** | For two individuals the systemic practice of implementing a 9pm "bed time" and utilizing time-out for swearing was being utilized. The agency needs to ensure that all practices that limit an individual's rights are referred to the HRC for their review and approval. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L61 | | **Indicator** | Health protection in ISP | | **Area Need Improvement** | For two out of five individuals with supportive devices, the plan in place did not contain what type or the frequency of safety checks. The agency needs to ensure that for all supports and health related protections all the required components are in place. | | **Status at follow-up** | For six of seven individuals, required information pertaining to medical supports and health related protections were in place. | | **#met /# rated at followup** | 6/7 | | **Rating** | Met | |  | | | **Indicator #** | L63 | | **Indicator** | Med. treatment plan form | | **Area Need Improvement** | For five of seven individuals reviewed medication treatment plans (MTP) were not written with all the required components. Two plans were not in place, one plan did not have all medications listed, and for two plans data was not being tracked at outline in the MTP. The agency needs to ensure that MTPs are present, list all medications, and that data is being tracked and shared with the prescribing physician. | | **Status at follow-up** | Five of seven behavior modifying treatment plans were in place, however for two plans, data was not being collected, or behaviors were not defined in observable terms. The agency needs to ensure that medication treatment plans define behavior observable terms, and that data is collected for each behavior identified within plans. | | **#met /# rated at followup** | 5/7 | | **Rating** | Not Met | |  | | | **Indicator #** | L64 | | **Indicator** | Med. treatment plan rev. | | **Area Need Improvement** | The medication treatment plans for 5 out of 6 individuals had not received the required reviews. The agency needs to ensure that all medication treatment plans receive review through the ISP process. | | **Status at follow-up** | All three medication treatment plans reviewed had been included in ISP's. | | **#met /# rated at followup** | 3/3 | | **Rating** | Met | |  | | | **Indicator #** | L67 | | **Indicator** | Money mgmt. plan | | **Area Need Improvement** | Six out of nine individuals who receive support with managing their funds, did not have a written money management plan or the plan did not outline the level of support the individual needed or was provided. The agency needs to ensure all individuals have a written money management plan with all required components when the agency has shared or delegated money management responsibility. | | **Status at follow-up** | In two instances where the agency had shared or delegated money management responsibility, training plans were not in place. The agency needs to ensure that training plans contain an element of teaching so as to reduce or eliminate the need for staff support. | | **#met /# rated at followup** | 5/7 | | **Rating** | Not Met | |  | | | **Indicator #** | L68 | | **Indicator** | Funds expenditure | | **Area Need Improvement** | Two of the nine individuals had expenditures that did not directly benefit the individual. The agency needs to ensure all expenditures of funds are made for purposes that directly benefit the individual. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L69 | | **Indicator** | Expenditure tracking | | **Area Need Improvement** | Expenditures were reviewed for nine individuals. For two individuals, required receipts for purchases were missing, and there was a lack of a financial expenditure tracking. The agency needs to ensure individuals' expenditures are documented and tracked accurately, and that receipts are maintained in accordance with agency's financial policies. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L70 | | **Indicator** | Charges for care calc. | | **Area Need Improvement** | Charges for Care were reviewed for 10 individuals. For two individuals, the agency did not provide an explanation of how their charges for care were calculated. Another individual did not have an explanation for the calculation of additional charges added to their charges for care. The agency needs to provide individuals and rep payees an explanation of how charges for care are calculated. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L78 | | **Indicator** | Restrictive Int. Training | | **Area Need Improvement** | For one of two restrictive practices reviewed, staff had not been trained proper use of a device. For all restrictive interventions the agency needs to ensure comprehensive training is provided to ensure effective implementation of restrictive practices. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L85 | | **Indicator** | Supervision | | **Area Need Improvement** | In two out of seven homes, adequate supervision from management was not being provided as evidenced by systemic issues identified regarding health care coordination/oversight, medication monitoring, safe evacuation, and long-standing environmental concerns. The agency needs to provide regular supervision and oversight to ensure that individuals have optimal living conditions, and staff are provided with training and tools to ensure the health and safety of individuals in their care. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L86 | | **Indicator** | Required assessments | | **Area Need Improvement** | For two individuals, ISP assessments were not submitted within the required timelines. The agency needs to ensure that all assessments are submitted in preparation for the ISP 15 days in advance of the scheduled ISP Meeting. | | **Status at follow-up** | ISP assessments for two of two individuals had not been submitted to the DDS Area Office at least 15 days prior to the ISP meetings. The agency needs to ensure that ISP assessments are submitted at least 15 days prior to ISP meetings. | | **#met /# rated at followup** | 0/2 | | **Rating** | Not Met | |  | | | **Indicator #** | L87 | | **Indicator** | Support strategies | | **Area Need Improvement** | For three individuals reviewed, ISP assessments were not submitted within the required timelines. The agency needs to ensure that all assessments are submitted in preparation for the ISP 15 days in advance of the scheduled ISP Meeting. | | **Status at follow-up** | ISP support strategies for two of two individuals had not been submitted to the DDS Area Office at least 15 days prior to the ISP meetings. The agency needs to ensure that ISP support strategies are submitted at least 15 days prior to ISP meetings. | | **#met /# rated at followup** | 0/2 | | **Rating** | Not Met | |  | | | **Indicator #** | L90 | | **Indicator** | Personal space/ bedroom privacy | | **Area Need Improvement** | Three out of eleven individuals did not have locks on their bedroom doors to allow them privacy. The agency needs to ensure that all individuals, unless clinically contraindicated or if the bedroom leads to an egress, have locks on their bedroom doors to provide the option of privacy. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L91 | | **Indicator** | Incident management | | **Area Need Improvement** | In two homes incident reports were not submitted within the required timelines. The agency needs to ensure that all incidents are submitted and finalized as mandated by regulation. | | **Status at follow-up** | The agency has revised its system for monitoring incident report submission and finalization timelines. Senior managers check HCSIS daily, and middle managers have been retrained on timeline requirements. For one of two locations audited, incident reports continue to either be submitted or finalized past the required timelines. The agency needs to continue to focus on ensuring timelines for submission and finalization are met. | | **#met /# rated at followup** | 1/2 | | **Rating** | Not Met | |  | | | **Employment and Day Supports Areas Needing Improvement on Standard not met - Identified by DDS** | | | **Indicator #** | L8 | | **Indicator** | Emergency Fact Sheets | | **Area Need Improvement** | One of the two emergency fact sheets reviewed did not contain all of the individual's diagnoses. The agency needs to ensure all emergency fact sheets are accurate. | | **Status at follow-up** |  | | **#met /# rated at followup** |  | | **Rating** | Not Rated | |  | | | **Indicator #** | L87 | | **Indicator** | Support strategies | | **Area Need Improvement** | Support strategies for one individual 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** | ISP support strategies for three individuals had been submitted to the Area Office at least 15 days prior to ISP meetings. | | **#met /# rated at followup** | 3/3 | | **Rating** | Met | |  | | | | |