

**DEPARTMENT OF DEVELOPMENTAL SERVICES**  
**LICENSURE AND CERTIFICATION**  
**PROVIDER FOLLOW-UP REPORT**

**Provider:** LATHAM CENTERS \_\_\_\_\_

**Provider Address:** 259 Willow St , Yarmouth Port \_\_\_\_\_

**Name of Person** Gina Sheehan \_\_\_\_\_  
**Completing Form:** \_\_\_\_\_

**Date(s) of Review:** 08-JAN-24 to 11-JAN-24 \_\_\_\_\_

<b>Follow-up Scope and results :</b>		
Service Grouping	Licensure level and duration	# Indicators std. met/ std. rated
Remote Supports and Monitoring Services		3/3
Residential and Individual Home Supports	Defer Licensure	4/4

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

<b>Indicator #</b>	L7
<b>Indicator</b>	Fire Drills
<b>Area Need Improvement</b>	In one of three locations, fire drills were not conducted in accordance with the approved safety plan. The agency needs to ensure that fire drills are conducted as stated in the safety plan.
<b>Process Utilized to correct and review indicator</b>	The agency has an internal audit process implemented and timely completion of the fire drills is one of the items to check on the audit form. The agency has a fire drill calendar, so everyone is on the same rotation making oversight easier. The task of updating the fire drill calendar is assigned to an administrator.
<b>Status at follow-up</b>	New Calendar has been sent out. Results of first audits in 2024 suggest we are on track with fire drills.
<b>Rating</b>	Met

<b>Indicator #</b>	L86
<b>Indicator</b>	Required assessments
<b>Area Need Improvement</b>	Four of six ISP timelines reviewed did not meet the required timelines for submission of ISP assessments. The agency needs to ensure that required ISP timelines for the submission of assessments are adhered to.
<b>Process Utilized to correct and review indicator</b>	New Audit Schedule. Audits are now occurring 30 days before the ISP to review ISP timelines. Audit occurs and manager uses the time to complete the process for submission of ISP assessments.
<b>Status at follow-up</b>	Results of the first audits in 2024 suggest we are on track. Managers report the new structure and process is helpful to adhere to the timelines.

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<b>Rating</b>	Met
<b>Indicator #</b>	L87
<b>Indicator</b>	Support strategies
<b>Area Need Improvement</b>	Five of six ISP timelines reviewed did not meet the required timelines for submission of ISP support strategies. The agency needs to ensure that required ISP support strategies for the submission of assessments are adhered to.
<b>Process Utilized to correct and review indicator</b>	New Audit Schedule which includes oversight of the ISP timelines. Audits are now occurring 30 days before the ISP to review ISP timelines. Audit occurs and manager uses the time to complete the process for submission of ISP support strategies.
<b>Status at follow-up</b>	Results of the first audits in 2024 suggest we are on track. Managers report the new structure and process is helpful to adhere to the timelines.
<b>Rating</b>	Met

**Remote Supports and Monitoring Services Areas Needing Improvement on Standard not met - Identified by DDS**

<b>Indicator #</b>	L8
<b>Indicator</b>	Emergency Fact Sheets
<b>Area Need Improvement</b>	For three of six individuals the emergency fact sheet (EFS) did not include all significant medical diagnoses. The agency needs to ensure that all significant medical diagnoses are included on the EFS.

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<b>Process Utilized to correct and review indicator</b>	The agency reviewed the entire audit process to place measures for follow up. Audit tool has been edited to include the following: Does the Health Care Report (HCSIS) match the physicians order and match the emergency fact sheets, esp diagnoses?
<b>Status at follow-up</b>	On going oversight throughout year and audit process
<b>Rating</b>	Met

<b>Indicator #</b>	L10
<b>Indicator</b>	Reduce risk interventions
<b>Area Need Improvement</b>	For two individuals with identified risks, monitoring staff had not received information on how to support the individual and/or action steps to take to minimize the impact of their risks. The agency needs to ensure all staff are knowledgeable about interventions to reduce risk for individuals whose behaviors may pose a risk to themselves or others.
<b>Process Utilized to correct and review indicator</b>	<p>For Group Homes established a new training tool: a comprehensive knowledge center in each group home for optimal operations. This area, known as the "HUB", will serve as a comprehensive repository of information essential for working in the group home environment. The HUB is developed as a central location for helpful and mandatory information that needs to be relayed to staff before working on the floor. Each area contains a site-specific binder with information on interventions to reduce risk.</p> <p>For remote supports and monitoring: Safe in-Home staff were provided and completed signs and symptoms training. Agency created a diagnosis specific training for the populations needs/risks. Safe in Home adopted training and will have trained all staff by January 30th, 2024.</p>

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<b>Status at follow-up</b>	Met and Training for SIH to be completed by end of January
<b>Rating</b>	Met

<b>Indicator #</b>	L80
<b>Indicator</b>	Symptoms of illness
<b>Area Need Improvement</b>	Monitoring staff did not receive training in Health Observation Guidelines and "Just Not Right". The agency needs to ensure that all staff receive training to recognize signs and symptoms of illness.
<b>Process Utilized to correct and review indicator</b>	The agency ensured that the safe in-home staff were provided and completed the training. Agency created a diagnosis specific training for the populations needs/risks.
<b>Status at follow-up</b>	Signs and Symptoms Training completed. Safe in Home adopted training and will have trained all staff by January 30th, 2024.
<b>Rating</b>	Met

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

<b>Indicator #</b>	L65
<b>Indicator</b>	Restraint report submit
<b>Area Need Improvement</b>	The agency did not meet the required timelines for the submission and/or finalization of restraints for twenty restraints. There was one restraint not filed. The agency needs to ensure that all restraints are filed within HCSIS while meeting the required timelines.
<b>Process Utilized to correct and review indicator</b>	The agency filed the restraint which was discovered as not entered. The Vice President of Adult Services intermittently runs reports to check the timelines for submission. The QE Department presents timeline compliance once per quarter at agency risk meeting. Reviews of the reports take place weekly following QE visit in the fall to ensure all reports are entered in a timely fashion.
<b>Status at follow-up</b>	Vice President of Adult Services pulled report of restraints Oct 1-Nov 1. There were 15 restraints. All were entered within the timelines.
<b>Rating</b>	Met