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

**Provider:** Northeast ED and Develop. Support Ctr.

**Provider Address:** 1390 Main Street , Tewksbury

**Name of Person Completing Form:** Kelley Campbell

**Date(s) of Review:** 01-MAY-22 to 13-JUN-22

| **Follow-up Scope and results :** | | |
|---|---|---|
| Service Grouping | Licensure level and duration | # Indicators std. met/ std. rated |
| Residential and Individual Home Supports | | |
| Employment and Day Supports | 2 Year License | |

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# PROVIDER FOLLOW-UP REPORT

## Summary of Ratings

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

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| **Indicator #** | L15 |
| **Indicator** | Hot water |
| **Area Need Improvement** | At two locations, water temperatures were found to be outside of the required range.<br>The agency needs to ensure that water temperature at all sink, tub and showers fall within required range (sinks: 110-120 degrees, tub/shower 110-112 degrees). |
| **Process Utilized to correct and review indicator** | Upon review of the water temperature in question, it was determined that at one house the hot water tank had just been replaced and staff were not able to set the temperature to the range required. At the second location, it was determined that staff took the water temperature three weeks prior, and it was in range however they didn't take the temperature at two different locations within the home. |
| **Status at follow-up** | A water temperature log was updated to instruct staff to take the water temperature every month and from the kitchen sink and one bathroom tub. The Director of QI and Compliance and safety committee reviewed each log to ensure water temperatures were in range. The dates to score this was 5/9/2022 to 6/13/2022. |
| **Rating** | Met |

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| **Indicator #** | L39 |
| **Indicator** | Dietary requirements |
| **Area Need Improvement** | For one individual, dietary recommendations from a consulting nutritionist spanning 2019 to present were not followed in regard to the daily calorie intake suggested for this person in consultation |

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| | notes. The agency needs to ensure that staff receive training on any dietary requirements a person is recommended to follow for good health so that they are best equipped on how to implement recommendations. The agency needs to ensure review of clinical recommendations so that any contradictions can be queried and the entire team fully informed. |
| **Process Utilized to correct and review indicator** | Upon review of the Individual in question it was determined that staff had been knowledgeable concerning specialized calorie intake. It was determined that the consultation recommendations had been following however staff had not signed off on a dietary plan or received training on the dietary plan. The agency has created a dietary plan for the individual in question which included the clinical recommendation of a low-calorie intake. The individual continues to be on the agency's list of individuals identified as risk for weight management obstacles. Staff are to bring copies of all consults and medical recommendations to all medical appointments to ensure entire team is informed of all consults and recommendations to avoid contradictions. |
| **Status at follow-up** | A review of four dietary plans were reviewed to ensure staff are knowledgeable<br>concerning specialized diets and to ensure entire team was informed for all recommendations for the individuals. |
| **Rating** | Met |

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| **Indicator #** | L91 |
| **Indicator** | Incident management |
| **Area Need Improvement** | At two locations, during a 13 month period reviewed, there were incidents which had not been reported within the required time frames. The agency needs to ensure that all incidents are submitted and finalized within the required time frames: major incidents require submission within one business day, finalization within seven |

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| | business days, minor incident reports require submission within three business days and finalization within seven business days. |
| **Process Utilized to correct and review indicator** | Upon review of the incident reports in question, it was determined that the staff responsible for submitting the reports was not in the office during the timeframe in which review, and submission was required. The agency has implemented a practice of identifying an alternate secondary staff who will be responsible for review and submission of restraint reports when the primary reviewer is out of the office. This system was implemented effective May 1, 2022, and the system was evaluated on June 9, 2022. |
| **Status at follow-up** | On June 9, 2022, a HCSIS report was generated. There was a total of 47 incidents both major and minor. Out of the 47 report timelines, 5 timelines were not met. Upon review of why the timelines were not met, staff needed to delete the original reports due to incorrect/ non neutral writing. Training have been created and in process to eliminate this obstacle to the required timelines.<br>The dates used to score this was May 1,2022 to June 9,2022 |
| **Rating** | Met |

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

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| **Indicator #** | L86 |
| **Indicator** | Required assessments |
| **Area Need Improvement** | For four individuals, required ISP assessments had not been submitted within required timeframes. The agency needs to ensure that ISP assessments are submitted at least 15 days prior to the ISP meeting. |
| **Process Utilized to correct and review indicator** | Upon review of the assessments in question, it was determined that the staff responsible for submitting the required assessments did not do so during the timeframe in which submission was required. This was due to several reasons, the largest being the COVID-19 pandemic. The agency has implemented a practice of identifying an |

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| | alternate secondary staff who will be responsible for submitting and reviewing all assessments and HCSIS alerts. This system was implemented effective May 9, 2022, and the system was evaluated on June 9, 2022. |
| **Status at follow-up** | On June 9, 2022, a HCSIS report was generated. Upon investigation of why two deadlines were not met it was established that one of the assessments was late due to a SC requesting it late. One assessment was not completed in a timely fashion.<br>The dates used to score this was May 9,2022 to June 9,2022.<br>We had a total of 13 individuals that had assessments due within that timeframe. We missed 2 deadlines. |
| **Rating** | Met |

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| **Indicator #** | L87 |
| **Indicator** | Support strategies |
| **Area Need Improvement** | For four individuals, required ISP support strategies had not been submitted within required timeframes. The agency needs to ensure that ISP support strategies are submitted at least 15 days prior to the ISP meeting. |
| **Process Utilized to correct and review indicator** | Upon review of the Support Strategies in question, it was determined that the staff responsible for submitting the required Support Strategies did not do so during the timeframe in which submission was required. This was due to several reasons, the largest being the COVID-19 pandemic. The agency has implemented a practice of identifying an alternate secondary staff who will be responsible for submitting and reviewing all Support Strategies and HCSIS alerts. This system was implemented effective May 9, 2022, and the system was evaluated on June 9, 2022. |
| **Status at follow-up** | On June 9, 2022, a HCSIS report was generated. Upon investigation of why two deadlines were not met it was established |

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| | that one of the individuals support strategies was late due to a SC requesting it late. One of the individuals support strategies were not completed in a timely fashion.<br>The dates used to score this was May 9,2022 to June 9,2022.<br>We had a total of 13 individuals that had support strategies due within that timeframe. We missed 2 deadlines. |
| **Rating** | Met |

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| **Indicator #** | L88 |
| **Indicator** | Strategies implemented |
| **Area Need Improvement** | For two individuals, ISP objectives are either not being implemented according to the outlined support strategies, or data collection is not occurring. The agency needs to ensure that ISP objectives are implemented as described within support strategies, and that data collection is occurring. |
| **Process Utilized to correct and review indicator** | Upon review of the two individuals in question it was determined that ISP objectives were being implemented for both individuals however data collection was not occurring when an individual refused an opportunity to work on their goal or documentation on how staff were implementing the support strategies to assist the individuals in meeting their goals. The agency has provided a staff training to staff to strengthen documentation when individuals refuse to work on a goal. The agency has providing additional training to staff on approaches to implement support strategies to support individuals to meet goals agreed upon. |
| **Status at follow-up** | On June 9th, 2022, the Director of Quality Improvement and Compliance (DQIC) reviewed a total of four support strategies and the corresponding data collection for the individual. Each data collection sheet had refusals documented and provided information on what support strategy was used to help support the individuals on meeting their goal. |

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| **Rating** | Met |

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| **Indicator #** | L91 |
| **Indicator** | Incident management |
| **Area Need Improvement** | At one location, during a 13 month period reviewed, there were incidents which had not been reported within the required time frames. The agency needs to ensure that all incidents are submitted and finalized within the required time frames: major incidents require submission within one business day, finalization within seven business days, minor incident reports require submission within three business days and finalization within seven business days. |
| **Process Utilized to correct and review indicator** | Upon review of the incident reports in question, it was determined that the staff responsible for submitting the reports was not in the office during the timeframe in which review, and submission was required. The agency has implemented a practice of identifying an alternate secondary staff who will be responsible for review and submission of restraint reports when the primary reviewer is out of the office. This system was implemented effective May 9, 202 and the system was evaluated on June 9, 2022. |
| **Status at follow-up** | On June 9, 2022, a HCSIS report was generated. There was a total of 1 incident. All timelines were met.<br>The dates used to score this was May 9,22 to June 9,22 |
| **Rating** | Met |

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

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| **Indicator #** | L65 |
| **Indicator** | Restraint report submit |
| **Area Need Improvement** | Thirty-four restraint reports were not submitted within required timelines either at the initial input and/or finalization level within |

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| | HCSIS. The agency needs to ensure that restraint reports are submitted within required timelines. |
| **Process Utilized to correct and review indicator** | Upon review of the restraint reports in question, it was determined that there were multiple reasons staff responsible for submitting the reports didn't not make the timeframe in which review band submission was required. The agency has implemented a practice of the Administer on Call (AOC) also notifying the Director of QI and Compliance (DQIC) of all restraints to ensure the timeframe in being met. The DQIC will run HCSIS reports and will cross reference the HCSIS reports to the reports of the AOC. This system was implemented effective May 9, 2022; the system was evaluated on June 9, 2022. |
| **Status at follow-up** | On June 9, 2022, a HCSIS report was generated. There was a total of 16 restraints. 2 restraint timelines were not met. Upon investigation of why two deadlines were not met it was established that the timelines were missed at the restraint management level. The agency will add more restraint managers to HCSIS to ensure all timelines are met.<br>The dates used to score this was May 9,2022 to June 9,2022. |
| **Rating** | Met |