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| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Mid-Cycle Scope and results :** | | | | | | | | | Service Grouping | Licensure level and duration | # Indicators std. met/ std. rated at Mid-Cycle | Sanction status prior to Mid-Cycle | | Combined Results post- Mid-Cycle; | Sanction status post Mid-Cycle | | | Residential and Individual Home Supports | Defer Licensure | 13/23 | x | Eligible for new business | 2 Year License with Mid-Cycle Review 77/87 (88.51% ) | x | Eligible for New Business (80% or more std. met; no critical std. not met) | | 6 Locations  9 Audits |  |  | o | Ineligible for new business. |  | o | Ineligible for New Business (<=80% std met and/or more critical std. not met) | |

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| |  | | --- | |  | | |  |  | | --- | --- | | **Organizational Areas Needing Improvement on Standards not met:** | | | **Indicator #** | L48 | | **Indicator** | HRC | | **Area Need Improvement** | Although the agency has a Human Rights Committee, there are a number of areas such as mandated composition, attendance and review of agency policy and procedures that potentially impact the rights of individuals that the agency needs to strengthen in order to improve its effectiveness. The agency needs to ensure that its Human Rights Committee serves as an effective safeguard for all individuals. | | **Status at mid-cycle** | The Human Rights Committee has held four meetings since 1/2020. The Committee meets membership composition requirements, and meeting minutes reflect regulatory compliance, including quorum and expertise attendance. Meeting minutes included review and discussion of a number of issues, including complaints/investigations, restraints, restrictive interventions, and supports and health related protections. | | **#met /# rated at mid-cycle** | 1/1 | | **Rating** | MET | |  |  | | **Indicator #** | L65 | | **Indicator** | Restraint report submit | | **Area Need Improvement** | Eight restraint reports were reviewed. Of these, six did not meet required timeframes regarding the creation of the report as well as the finalization of the report in the department's HCSIS system. The agency needs to ensure that restraint reports are submitted and finalized within required timelines. | | **Status at mid-cycle** | Five restraints of the eight restraint reports reviewed were submitted within the required timelines. Three did not meet required timeframes regarding the finalization of the report. The agency needs to ensure that restraint reports are finalized within required timelines. | | **#met /# rated at mid-cycle** | 5/8 | | **Rating** | NOT MET | |  |  | | **Indicator #** | L83 | | **Indicator** | HR training | | **Area Need Improvement** | All agency staff were not trained in the mandated reporting requirements that were required by April 1, 2018. A Notice of Action was issued. The agency needs to ensure that all staff are trained in the most current mandated reporting requirements. | | **Status at mid-cycle** | Of the thirteen staff reviewed, all staff had received Human Rights and Mandated Reporting training. | | **#met /# rated at mid-cycle** | 13/13 | | **Rating** | MET | |  |  | | **Residential and Individual Home Supports Areas Needing Improvement on Standards not met:** | | | **Indicator #** | L1 | | **Indicator** | Abuse/neglect training | | **Area Need Improvement** | Of the nine individuals reviewed, six guardians were not provided information regarding how to report potential abuse and neglect. The agency needs to ensure that all guardians are knowledgeable regarding reporting potential abuse and neglect. | | **Status at mid-cycle** | Five of the nine individuals reviewed had been trained and their guardian had received information regarding reporting abuse/neglect. For one individual, both of their co-guardians had not received information regarding reporting abuse/neglect. Three individuals had not been trained regarding reporting abuse/neglect. The agency needs to ensure that all guardians receive information and that all individuals are trained on reporting abuse/neglect. | | **#met /# rated at mid-cycle** | 5/9 | | **Rating** | NOT MET | |  |  | | **Indicator #** | L5 | | **Indicator** | Safety Plan | | **Area Need Improvement** | In two of seven locations, required safety plan components were not in place including training of all staff, accurate descriptions of individuals' support needs and action steps to be implemented in the event that individuals are resistant to safely evacuate within allowable timeframes. The agency needs to ensure that approved safety plans are in place with all required components. | | **Status at mid-cycle** | At five of the six locations reviewed, the safety plans had all the required components and staff were trained. At one location there were multiple shifts that there was not an adequate number of staff trained in the safety plan on shift. | | **#met /# rated at mid-cycle** | 5/6 | | **Rating** | MET | |  |  | | **Indicator #** | L38 | | **Indicator** | Physician's orders | | **Area Need Improvement** | For three out four individuals, staff were not aware of or knowledgeable regarding their unique health management protocols. The agency needs to ensure that all staff are trained and are following treatment protocols as outlined by the physician. | | **Status at mid-cycle** | Seven of the eight individuals reviewed had healthcare management plans that had all of the required components and staff were adequately trained on these plans. For one individual, the healthcare management plan, staff did not have adequate knowledge of the plan. The agency needs to ensure that all healthcare managements plans have the required components, that staff are knowledgeable regarding these plans, and that there is adequately trained staff on all shifts. | | **#met /# rated at mid-cycle** | 7/8 | | **Rating** | MET | |  |  | | **Indicator #** | L39 | | **Indicator** | Dietary requirements | | **Area Need Improvement** | For two out of four individuals who required specialized diets, all staff were not trained to support individuals to follow dietary recommendations. The agency needs to ensure that staff are implementing and supporting individuals to follow special dietary recommendations. | | **Status at mid-cycle** | Two of the four individuals who required specialized diet were being supported to meet these dietary needs. For one individual it was unclear what their dietary needs were as proper follow-up to a swallow evaluation had not occurred. For another individual the system for tracking fluid intake was not being used effectively. The agency needs to ensure that all individuals are supported to follow special dietary needs. | | **#met /# rated at mid-cycle** | 2/4 | | **Rating** | NOT MET | |  |  | | **Indicator #** | L43 | | **Indicator** | Health Care Record | | **Area Need Improvement** | The health care record (HCR) for two individuals did not accurately reflect all of the individuals' medical information. The agency needs to ensure that health care records are updated. | | **Status at mid-cycle** | For the eight individuals reviewed, seven of the health care records (HCRs) were accurate and up to date. For one individual historical diagnoses were not accurate. The agency needs to ensure that HCRs are accurate and updated as required. | | **#met /# rated at mid-cycle** | 7/8 | | **Rating** | MET | |  |  | | **Indicator #** | L47 | | **Indicator** | Self medication | | **Area Need Improvement** | Four out of six individuals were not assessed regarding their ability to self-medicate. The agency needs to ensure that individuals are assessed regarding their ability to administer their medications. | | **Status at mid-cycle** | Four individuals reviewed were self medicating. All the individuals were assessed regarding their ability to self-medicate and were being supported to maintain this skill. | | **#met /# rated at mid-cycle** | 4/4 | | **Rating** | MET | |  |  | | **Indicator #** | L49 | | **Indicator** | Informed of human rights | | **Area Need Improvement** | Six out of nine individuals and their guardians were not informed of how to file a grievance. The agency needs to ensure that individuals are informed and trained regarding the agency's grievance procedures, or to whom they should talk to if they have a concern. | | **Status at mid-cycle** | Three of the nine individuals reviewed had been trained and their guardian had received information regarding human rights and the grievance procedure. Six individuals were not provided training on the agency's grievance procedure. The agency need to ensure that all individuals are trained. | | **#met /# rated at mid-cycle** | 3/9 | | **Rating** | NOT MET | |  |  | | **Indicator #** | L55 | | **Indicator** | Informed consent | | **Area Need Improvement** | In seven instances the agency obtained consent without identifying the purpose, the actual photo being utilized or to whom the information would be released. The agency needs to ensure that when informed consent is obtained from individuals or guardians, all required information is included. | | **Status at mid-cycle** | Of the nine individuals reviewed, the agency had obtained consent for the publication of photos for eight individuals and all required information was present. For one individual consent was obtained from the individual, however consent was not sought from their guardian. | | **#met /# rated at mid-cycle** | 8/9 | | **Rating** | MET | |  |  | | **Indicator #** | L56 | | **Indicator** | Restrictive practices | | **Area Need Improvement** | For one individual out of three with restrictive practices, all required components such as a written rationale and a plan to fade were not in place. The agency needs to ensure that all required components are in place when restrictive practices are being implemented. | | **Status at mid-cycle** | There were five instances in which restrictive practices were present. For four of these instances all components were present and approvals were present. For one individual, their plan did not include an attempt to use a less restrictive practice and it also did not include a plan to fade the restriction. . The agency needs to ensure that restrictive practices have all of the required components. | | **#met /# rated at mid-cycle** | 4/5 | | **Rating** | MET | |  |  | | **Indicator #** | L60 | | **Indicator** | Data maintenance | | **Area Need Improvement** | For one individual out of three with behavior plans, there was a lack of implementation of all identified strategies. The agency needs to ensure that staff are supported to implement behavior plans as designed. | | **Status at mid-cycle** | One individual reviewed required the use of a behavior support plan. The plan is being implemented as outlined and data was present. | | **#met /# rated at mid-cycle** | 1/1 | | **Rating** | MET | |  |  | | **Indicator #** | L61 | | **Indicator** | Health protection in ISP | | **Area Need Improvement** | Supportive and health related protections were reviewed for two individuals. For one individual all required components such as the frequency of use and procedures for safety checks were not included. The agency needs to ensure that all required information is in place to ensure proper utilization of such supports. | | **Status at mid-cycle** | One of the four individuals reviewed had all of the required components and authorizations. For three individuals safety checks were not being completed. Additionally there was a lack of criteria for discontinuance for two individuals' devices and one of these individual's devices had not been approved by a health care practitioner. The agency needs to ensure that all supportive and health related protections have the required information in place and that safety checks are occurring as outlined. | | **#met /# rated at mid-cycle** | 1/4 | | **Rating** | NOT MET | |  |  | | **Indicator #** | L62 | | **Indicator** | Health protection review | | **Area Need Improvement** | A supportive and health protection was not reviewed by the human rights committee. The agency needs to ensure that supportive and health related protections are reviewed by required groups. | | **Status at mid-cycle** | Of the four individuals reviewed, three had their supportive and health related protections approved by the human rights committee (HRC). One individual did not have HRC approval for the use of their supportive and health related protections. | | **#met /# rated at mid-cycle** | 3/4 | | **Rating** | MET | |  |  | | **Indicator #** | L63 | | **Indicator** | Med. treatment plan form | | **Area Need Improvement** | Medication Treatment Plans (MTP) were reviewed for seven individuals. Issues were identified regarding two of these plans including a lack of data collection needed to inform the prescribing physician regarding the effectiveness of the medication and a plan to reduce the need for the medication. The agency needs to ensure that MTP's include all required components. | | **Status at mid-cycle** | Seven individuals reviewed required a medication treatment plan (MTP). All seven MTPs had all of the required components. | | **#met /# rated at mid-cycle** | 7/7 | | **Rating** | MET | |  |  | | **Indicator #** | L64 | | **Indicator** | Med. treatment plan rev. | | **Area Need Improvement** | Two medication treatment plans were not reviewed by the ISP team. The agency needs to ensure that medication treatment plans are reviewed by the ISP team. | | **Status at mid-cycle** | Four individuals reviewed that required a MTP had them reviewed by the ISP team. Two individuals did not have current Roger's Monitor but the agency is working to actively rectifying these. | | **#met /# rated at mid-cycle** | 4/4 | | **Rating** | MET | |  |  | | **Indicator #** | L69 | | **Indicator** | Expenditure tracking | | **Area Need Improvement** | In four instances out of seven reviewed, staff were not documenting cash taken out of cash on hand. The agency needs to ensure that all expenditures are documented and tracked. | | **Status at mid-cycle** | For five of the nine individuals reviewed all expenditures were documented and tracked. For two individuals cash and gift cards were not being tracked appropriately. For two individuals there were concerns regarding assets being over the allowable limits. The agency needs to ensure that all cash/gift cards are tracked and that individual assets do not exceed $2000. | | **#met /# rated at mid-cycle** | 5/9 | | **Rating** | NOT MET | |  |  | | **Indicator #** | L84 | | **Indicator** | Health protect. Training | | **Area Need Improvement** | For one individual, the staff were not trained in the correct utilization of health related protections. The agency needs to ensure that all staff are trained in the correct utilization of health related supports and protections. | | **Status at mid-cycle** | For two of the individuals, there was not a sufficient number of staff trained in the correct utilization of health related protections. The agency needs to ensure that an adequate number of staff are trained in the correct utilization of health related supports and protections. | | **#met /# rated at mid-cycle** | 2/4 | | **Rating** | NOT MET | |  |  | | **Indicator #** | L85 | | **Indicator** | Supervision | | **Area Need Improvement** | At two out of seven locations, there was no evidence of supervisory oversight such as quality assurance reviews or regular staff meetings to identify areas that staff would need additional support and/or education to meet standards regarding individuals' health care management protocols, communication needs, supportive health related protections, evacuation procedures and dietary requirements. The agency needs to ensure that all staff are supported through supervision and training to meet the needs of the individuals. | | **Status at mid-cycle** | One location of the six reviewed had adequate supervision and oversight, while five did not. Areas of concern included a lack of staff meetings, a lack individual staff supervision, inadequate oversight of funds, and gaps in staff training. The agency needs to ensure that all staff are supported through supervision, staff meeting, and additional training to meet the needs of the individuals. | | **#met /# rated at mid-cycle** | 1/6 | | **Rating** | NOT MET | |  |  | | **Indicator #** | L86 | | **Indicator** | Required assessments | | **Area Need Improvement** | Assessments were not submitted within required timeframes for four individuals. The agency needs to ensure that assessments are submitted to the DDS Area office at least 15 days prior to the ISP. | | **Status at mid-cycle** | Four of the six individuals reviewed has their ISP assessments submitted with the required timelines. Two did not. The agency needs to ensure that all required assessments are submitted at least 15 days prior to the scheduled ISP meeting. | | **#met /# rated at mid-cycle** | 4/6 | | **Rating** | NOT MET | |  |  | | **Indicator #** | L87 | | **Indicator** | Support strategies | | **Area Need Improvement** | Support strategies were not submitted within required timeframes for five individuals. 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 mid-cycle** | Four of the seven individuals reviewed has their ISP support strategies submitted with the required timelines. Three did not. The agency needs to ensure that all support strategies are submitted at least 15 days prior to the scheduled ISP meeting. | | **#met /# rated at mid-cycle** | 4/7 | | **Rating** | NOT MET | |  |  | | **Indicator #** | L91 | | **Indicator** | Incident management | | **Area Need Improvement** | In three locations there were incidents that were not reported. In two of the seven locations where reportable incidents had occurred, there were instances in which reports had not been submitted and/or finalized within required timelines. The agency needs to ensure that all staff are knowledgeable of the criteria for reportable incidents and that these are reported within required timelines. | | **Status at mid-cycle** | Of the six locations reviewed, five had submitted all incidents report within the required timelines. At one location an incident report did not meet the timeline requirements. | | **#met /# rated at mid-cycle** | 5/6 | | **Rating** | MET | |  |  | | | |

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|  | |  | | --- | | **Mid-Cycle Detail Report** | |
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| |  |  |  | | --- | --- | --- | | **Licensure Organizational :** | | | | **Indicator** | **Source** | **Issue** | | L65 | Indi. Doc | 3 out of 8 restraints were not submitted within the required timelines. | | |
|  | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Residential and Individual Home Supports** | | | | | | | **Indicator** | | **Service Type** | **Location** | **Individual** | **Issue** | |  | L1 | Residential Services | 664 School Street Apt. #5 | CL | One of CL's co-guardians was not included on the agency's human rights information mailing list. | |  | L1 | Residential Services | 664 School Street Smith House - A | LB | The agency could not demonstrate that Linda was trained and knowledgeable of how to report abuse and neglect. | |  | L1 | Individual Home Supports | 664R School Street | PB | PB has not been provided with training on how to report alleged abuse and neglect. | |  | L1 | Individual Home Supports | NEW ENGLAND VILLAGES 664 SCHOOL ST, WATSON HOUSE 12 | JS | JS was not trained on how to recognize or report abuse/neglect. | |  | L5 | Residential Services | 664 School Street Fuller House |  | A review of staffing schedules revealed that there were multiple shifts that there was not an adequate number of staff trained in the safety plan on shift. | | O | L38 | Residential Services | 664 School Street Fuller House | SW | Staff interview revealed staff had limited knowledge around the use of Diastat/Ativan as outlined in the healthcare management plan. The Ativan on hand had expired 12/27/2020. | |  | L39 | Residential Services | 664 School Street Fuller House | SW | The health and dental assessment states a Video Fluoroscopic Swallow Study was attempted on 10/26/2017, but could not be successfully completed. It was recommended that an assessment be completed by a VNA at home and to continue with current food texture. There is no documentation available that outlines the ordered food texture nor was the bedside evaluation completed by the VNA. | |  | L39 | Residential Services | 664 School Street Smith House - A | ML | This person has a fluid intake guidelines of 1800 cc per day.   The agency has developed a system to monitor, however staff are not using the system, thus this is not effectively monitored. | |  | L43 | Individual Home Supports | NEW ENGLAND VILLAGES 664 SCHOOL ST, WATSON HOUSE 12 | JS | The past medical history does not note that JS has a history of seizures. | |  | L49 | Residential Services | 664 School Street Apt. #5 | CL | CL was not provided training on the agency's People Served Complaint Resolution Policy. | |  | L49 | Residential Services | 664 School Street Apt. #5 | JK | JK was not provided training on the agency's People Served Complaint Resolution Policy. | |  | L49 | Residential Services | 664 School Street Smith House - A | LB | Linda was not knowledgeable of a grievance procedure, nor was there documentation of training Linda in the agencies grievance procedure. | |  | L49 | Residential Services | 664 School Street Watson House - B, #13 | EB | The agency's Grievance Procedure was not included in the annual Human Rights training packet for individuals and EB did not know to whom she would report a concern. | |  | L49 | Individual Home Supports | 664R School Street | GC | GC was not provided training in the agency's People Served Complaint Resolution Policy. | |  | L49 | Individual Home Supports | 664R School Street | PB | PB was not provided training in the agency's People Served Complaint Resolution Policy. | |  | L55 | Individual Home Supports | NEW ENGLAND VILLAGES 664 SCHOOL ST, WATSON HOUSE 12 | JS | The informed consent regarding the use of photos was signed by JS. However, JS has a guardian from whom consent was not sought. | |  | L56 | Residential Services | 664 School Street Apt. #5 | CL | CL's restrictive plan does not include any prior use of less restrictive interventions related the current restricted access to sharps. There is no plan for fading of the sharps' restriction, only a process for clinical discussion at regularly scheduled clinical meetings. Documentation of clinical team meetings did not include any discussion of a plan for fading this restriction. | |  | L61 | Residential Services | 664 School Street Fuller House | DF | There is no criteria for discontinuance of the use of a wheelchair, hospital bed, Hoyer lift, and commode. These long-standing devices have not been approved by a Health Care Practitioner. Additionally, safety checks are not being completed as outlined. | |  | L61 | Residential Services | 664 School Street Fuller House | JR | There are no criteria for discontinuance of the use of JR's wheelchair, gait belt, or AFOs. Additionally, safety checks are not being completed as outlined. | |  | L61 | Residential Services | 664 School Street Watson House - B, #13 | EB | There is no evidence of safety checks being done on the gait belt for EB as outlined in the plan. | |  | L62 | Residential Services | 664 School Street Fuller House | DF | The use of a hospital bed with bedrails, and commode with seat belt has not been approved by the HRC. | |  | L64 | Residential Services | 664 School Street Apt. #5 | KD | KD has a Medication Treatment Plan for three behavior modifying medications (Luvox, Risperdal, and Trazadone). The Rogers Order for Risperdal expired on 8/16/19. | |  | L64 | Residential Services | 664 School Street Fuller House | SW | The court approved treatment plan expired in 2019. The agency is actively work with the physician to get an updated approved plan. This rating of not met is not included in the scoring. | |  | L64 | Individual Home Supports | 664R School Street | PB | The individual's Rogers Monitor has expired. The agency is actively working with the family and their lawyer to get an updated approved plan. | |  | L69 | Residential Services | 664 School Street Fuller House | DF | DF had purchased a $200 gift card. There was not a system in place to track the usage of the gift card. This card could not be accounted for. Staff stated they had "changed the card to cash", however cash had not been logged onto the FTRs. | |  | L69 | Residential Services | 664 School Street Smith House - A | ML | The agency is this person's rep payee. This individual has been significantly over asset limits for more than a year. | |  | L69 | Residential Services | 664 School Street Watson House - B, #13 | NR | Funds including cash and gift cards were not being tracked. Amounts documented for transactions were not reflective of receipt totals as it was stated that change was giving to individuals but not noted on FTR or receipts. Notice of Action issued. | |  | L69 | Individual Home Supports | NEW ENGLAND VILLAGES 664 SCHOOL ST, WATSON HOUSE 12 | JS | The agency is rep payee and it does not review the balance of her personal banking account to ensure her total assets are under $2,000. Rather they send the balance of the rep payee account to the staff to review. Staff stated they send the personal bank account statements to rep payee department to review. It unclear who is responsible to ensure she does not go over the allowable limits. Additionally, as a result of wages earned not reported she had overpayment of $22,000 for Social Security.  JS has not been supported to explore options such as ABLE account to protect her from exceeding allowable limits. Staff reported that if she is over assets, they will just take cash out of her account to reduce the amount. | |  | L84 | Residential Services | 664 School Street Fuller House | DF | A review of staffing schedules revealed that there were multiple shifts that there was not an adequate number of staff trained in DF's wheelchair, hospital bed, Hoyer lift, and commode. | |  | L84 | Residential Services | 664 School Street Fuller House | JR | A review of staffing schedules revealed that there were multiple shifts that there was not an adequate number of staff trained in JR's wheelchair, gait belt, and AFOs. | |  | L85 | Residential Services | 664 School Street Fuller House |  | Staff meeting have not occurred since March 2020. Formal supervisions with DSP are not occurring. There is no system to disseminate important information to staff. | |  | L85 | Residential Services | 664 School Street Smith House - A |  | Prior to the start of the pandemic, staff meetings and supervision were occurring, however such oversight was suspended from March to December 2020 and alternative methods such as the use of video conferring were not utilized. Oversight mechanism were reimplemented mid-December. An emphasis should be placed on monitoring that any staff that work alone have the necessary training, for instance, one of the staff that was not trained in ML's seizure protocol that worked alone 12/27/20. (Corrected) | |  | L85 | Residential Services | 664 School Street Watson House - B, #13 |  | There was insufficient oversight and guidance given for the management and documentation of individuals' funds. | |  | L85 | Individual Home Supports | 664R School Street |  | Staff meetings and supervision have not consistently occurred between March to December 2020. | |  | L85 | Individual Home Supports | NEW ENGLAND VILLAGES 664 SCHOOL ST, WATSON HOUSE 12 |  | There is a lack of oversight regarding training. Sometimes training occurred well after the practices should have been implemented and documentation could not be found for several trainings.  There is a lack of effective systems to obtain and convey necessary information to all staff that support JS and to ensure monitoring efforts are effective. For instance, staff stated that if anything important occurred it would be written on to white board for staff to read. Additionally, JS's mother often takes her to medical appointments, however staff typically provided an overview of recommendations from the healthcare practitioner. These methods do not allow supervisory staff to evaluate the full scope of what was or was not shared with staff nor provide the necessary information to determine if staff are implementing or providing the necessary guidance to JS implement any HCP recommendations. | |  | L86 | Residential Services | 664 School Street Smith House - A | ML | ISP assessments due 11/20/20 were not submitted. | |  | L86 | Individual Home Supports | 664R School Street | GC | Assessments due 12/24/19 submitted 12/26/19 & 1/2/2020 | |  | L87 | Residential Services | 664 School Street Smith House - A | ML | ISP objectives due 11/20/20 have not been developed. | |  | L87 | Individual Home Supports | 664R School Street | GC | Support strategies due 12/24/19 submitted 1/14/20 | |  | L87 | Individual Home Supports | NEW ENGLAND VILLAGES 664 SCHOOL ST, WATSON HOUSE 12 | JS | The support strategies due on 7/2/2020 were submitted on 7/21/2020. | |  | L91 | Residential Services | 664 School Street Apt. #5 |  | One incident report (#895561) did not meet DDS/HCSIS submission timeline requirements. | |