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| |  |  |  | | --- | --- | --- | | **Follow-up Scope and results :** |  |  | | Service Grouping | Licensure level and duration | # Indicators std. met/ std. rated | | Residential and Individual Home Supports | 2 Year License | 4/4 | |  |  |  | | Employment and Day Supports | 2 Year License | 2/2 | |  |  |  | | |  |

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| |  | | --- | | **Summary of Ratings** | |  |
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| |  |  | | --- | --- | |  |  | | |  |  | | --- | --- | | **Employment and Day Supports Areas Needing Improvement on Standard not met - Identified by DDS** | | | **Indicator #** | L77 | | **Indicator** | Unique needs training | | **Area Need Improvement** | For one individual, staff was not trained to support individuals unique needs. The agency needs to ensure that all staff are familiar with and trained to support the unique needs of individuals. | | **Process Utilized to correct and review indicator** | 1. For the specific individual identified - conduct training for all staff on her unique needs (Coumadin special considerations) 2. For all others - for people currently receiving services, review HCR and annual physical documents provided by residential provider to determine if there are any other "unique needs" that were missed and untrained. Conduct training of all staff on any areas identified.  3. As individuals return to the site, complete a review of HCR and medical documentation provided by residential provider, develop, and implement training as needed.  4. Going forward, involve nurse in review of materials provided by residential provider as they are forwarded (typically at ISP) | | **Status at follow-up** | Training was conducted with all program staff 5/12/21. Side effects, danger signs, appropriate actions, including foods to be avoided, were reviewed at the training. All appropriate documentation and informational posters have been filed/posted in appropriate locations in the program. A complete record review of all medical documentation for individuals who are actively attending the program was conducted and no other issues related to unique medical needs were found. As other participants are scheduled to return to the program, updated medical documentation will be requested from the residential providers and compared to HCR and EFS information and any outdated or missing protocols will be requested and appropriate training to occur. Moving forward, the agency nurse will review medical documentation forwarded by residential providers to ensure the program staff have all current and necessary training. | | **Rating** | Met | | **Indicator #** | L86 | | **Indicator** | Required assessments | | **Area Need Improvement** | For one individual, assessments had not been submitted to DDS 15 days prior in preparation for the ISP. The agency needs to ensure that assessments are completed and submitted in accordance with regulatory requirements in preparation for the ISP. | | **Process Utilized to correct and review indicator** | 1. Pull report from HCSIS on timelines/deadlines of submitted materials. 2. Develop ISP schedule/calendar for use by Case Managers responsible for submission of ISP documents. 3. When HCSIS timelines are not met due to issues with the system or Service Coordinator issues, document the issues and agency attempts at correction. 4. Regular monthly review of HCSIS deadline issues at RHD Admin/Directors meetings | | **Status at follow-up** | Weekly HCSIS status reports have been pulled and sent to all managers with upcoming dates. Managers have been instructed to keep detailed documentation on any submission issues related to ISP's not being opened by DDS on time to submit documents or timeline changes that are not communicated. Those issues will be documented in legal section of record and reviewed at Provider Meetings with State. Disciplinary action for any manager with repeat issues related to HCSIS submission. | | **Rating** | Met | | **Residential and Individual Home Supports Areas Needing Improvement on Standard not met - Identified by DDS** | | | **Indicator #** | L8 | | **Indicator** | Emergency Fact Sheets | | **Area Need Improvement** | Two of the seven individual's emergency fact sheets were missing information such as significant diagnoses. The agency needs to ensure that emergency fact sheets are regularly updated to include all required information. | | **Process Utilized to correct and review indicator** | 1. Make corrections on EFS sheets for the specific individuals identified in the survey. Completed: 7/1/21 2. Random review 10% of records in ALTR/IHS services. Completed: 7/8/21 3. Develop system of reviewing Annual Physical documents as those appointments occur by nurse in conjunction with Site Directors. Completed and conveyed to all managers at monthly meeting on 7/8/21. 4. Make appropriate changes to HCR and Emergency Fact Sheets in real time. | | **Status at follow-up** | All stated actions have been completed | | **Rating** | Met | | **Indicator #** | L43 | | **Indicator** | Health Care Record | | **Area Need Improvement** | Two out of the seven individual's health care records were missing information such as significant diagnoses. The agency needs to ensure that health care records are current and accurate. | | **Process Utilized to correct and review indicator** | 1. Make corrections on HCR for the specific individuals identified in the survey. Completed: 7/1/21 2. Random review 10% of records in ALTR/IHS services. Completed: 7/8/21 3. Develop system of reviewing Annual Physical documents as those appointments occur by nurse in conjunction with Site Directors. Completed and conveyed to all managers at monthly meeting on 7/8/21. Make appropriate changes to HCR and Emergency Fact Sheets in real time. | | **Status at follow-up** | All stated actions have been completed | | **Rating** | Met | | **Indicator #** | L61 | | **Indicator** | Health protection in ISP | | **Area Need Improvement** | There was no guidance for the cleaning and maintenance of supports and health-related equipment at one location. The agency needs to ensure that procedures are outlined for the checks and maintenance of all health-related equipment. | | **Process Utilized to correct and review indicator** | 1. Standardized cleaning and maintenance guidelines established for all S&P's used in the programs. 2. Guidelines added to current S&P forms 3. Site Directors implement procedures and ensure staff are aware. 4. Nurse will ensure both are included each time a new S&P is ordered and/or at the time of the annual review of the S&P | | **Status at follow-up** | All materials for standardized instructions have been reviewed with managers of programs. | | **Rating** | Met | | **Indicator #** | L87 | | **Indicator** | Support strategies | | **Area Need Improvement** | For three of seven individuals, support strategies were not submitted to DDS 15 days prior in preparation for the ISP. The agency needs to ensure that supports strategies are submitted within the required timeframe in preparation for the ISP. | | **Process Utilized to correct and review indicator** | 1. Weekly report to be sent out to all managers with HCSIS deadlines for materials to be submitted for review to SC's. 2. Maintain record of issues that are related to HCSIS that are out of the agency's control (e.g. HCSIS not opened by SC, HCSIS access opened after the deadline for submission, documents not requested prior to the ISP). 3. Person's responsible for late submission to receive corrective feedback on performance issues. | | **Status at follow-up** | These actions have been completed and process for ongoing monitoring has been established. | | **Rating** | Met | |  | | |