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|  | |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | |  | | --- | | **Provider:** | | |  | | --- | | Triangle, Inc. | |  | |  | | --- | | **Provider Address:** | | |  | | --- | | 420 Pearl St , Malden | |  | |  |  |  |  |  |  |  | |  | |  | | --- | | **Name of Person Completing Form:** | | |  | | --- | | Melissa Strout | |  | |  | | --- | | **Date(s) of Review:** | | |  | | --- | | 13-DEC-21 to 15-DEC-21 | |  | |  |
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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 | 7/7 | |  |  |  | | Employment and Day Supports | 2 Year License | 2/2 | |  |  |  | | |  |

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| |  | | --- | | **Summary of Ratings** | |  |
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| |  |  | | --- | --- | |  |  | | |  |  |  | | --- | --- | --- | | **Residential and Individual Home Supports Areas Needing Improvement on Standard not met - Identified by DDS** | | | | **Indicator #** | | L24 | | **Indicator** | | Locked door access | | **Area Need Improvement** | | In one out of three homes, the provider did not have keys for the locks on either of the two bathroom doors. In addition, the agency needs to ensure that staff carry a key or have the key readily available to open the door in the event of an emergency. | | **Process Utilized to correct and review indicator** | | During the OQE audit Triangle's maintenance department came in to the home and replaced the existing locks and provided new keys as well as spare keys. | | **Status at follow-up** | | Completed | | **Rating** | | Met | |  | | | | **Indicator #** | | L63 | | **Indicator** | | Med. treatment plan form | | **Area Need Improvement** | | For seven individuals, medication treatment plans were either not in place for all behavior modifying medications, or did not contain all the required components. Medication treatment plans should include all medications prescribed for behavioral purposes, and information regarding clinical indications to reduce or eliminate the drug therapy. | | **Process Utilized to correct and review indicator** | | An ISP checklist for clinically specific documents was completed as a way to make sure all appropriate documentation and information is completed and accounted for in preparation for an ISP. | | **Status at follow-up** | | Completed | | **Rating** | | Met | |  | | | | **Indicator #** | | L64 | | **Indicator** | | Med. treatment plan rev. | | **Area Need Improvement** | | For two individuals, medication treatment plans were not submitted for review in the individual's ISP. The agency needs to ensure that treatment plans are submitted for review by the ISP team. | | **Process Utilized to correct and review indicator** | | As part of the ISP checklist for clinically specific information a reminder was added to submit the documents into HCSIS. | | **Status at follow-up** | | Completed | | **Rating** | | Met | |  | | | | **Indicator #** | | L67 | | **Indicator** | | Money mgmt. plan | | **Area Need Improvement** | | The money management plans for three individuals were missing components and/or lacked a training plan designed to enhance their independence with managing their finances. The agency needs to ensure there is a written plan accompanied by a training plan, if applicable, for every individual for whom they have shared or delegated money management responsibility. | | **Process Utilized to correct and review indicator** | | The money management plan has been added to Triangle's ISP checklist. Once the plan is completed the Regional Manager reviews this. | | **Status at follow-up** | | Completed | | **Rating** | | Met | |  | | | | **Indicator #** | | L78 | | **Indicator** | | Restrictive Int. Training | | **Area Need Improvement** | | In one location, staff had not been trained to safely and consistently implement restrictive interventions. The agency needs to ensure that staff are trained and knowledgeable about the utilization of restrictive practices. | | **Process Utilized to correct and review indicator** | | Triangle utilizes a specific training that explains restrictive interventions are. Staff are trained on this as well as individual specific restrictions. | | **Status at follow-up** | | Completed | | **Rating** | | Met | |  |  | | | **Indicator #** | | L91 | | **Indicator** | | Incident management | | **Area Need Improvement** | | In two out of three homes, incidents were not submitted within the regulatory timelines. The agency needs to ensure that incidents are reported and reviewed as mandated by regulation | | **Process Utilized to correct and review indicator** | | As soon as incidents are submitted for agency review teams are to let the approving managers know. This should then trigger the approving manager to review and finalize the report. | | **Status at follow-up** | | Completed | | **Rating** | | Met | |  |  | | | **Employment and Day Supports Areas Needing Improvement on Standard not met - Identified by DDS** |  | | | **Indicator #** | | L7 | | **Indicator** | | Fire Drills | | **Area Need Improvement** | | At two locations, fire drills were not completed as required per the location approved Safety Plan. Additionally, fire drill reports were missing required information regarding staff members present during the drill, evacuation times and the level of independence exhibited by individuals. The agency needs to ensure that fire drills are conducted per the specifications laid out in the location Safety Plan and that fire drill reports contain all required information. | | **Process Utilized to correct and review indicator** | | During Monthly QA meetings fire drills are reviewed. These meetings occurred sporadically because of the COVID-19 Pandemic. We have worked to bring these back to a monthly procedure. During the most recent meetings we have reviewed the status of fire drills. We have also modified our fire drill form for day programs. | | **Status at follow-up** | | Modifications completed and fire drills are being reviewed monthly | | **Rating** | | Met | |  |  | | | **Administrative Areas Needing Improvement on Standard not met - Identified by DDS** |  | | | **Indicator #** | | L48 | | **Indicator** | | HRC | | **Area Need Improvement** | | The agency needs to ensure that it has an effective Human Rights Committee. While the agency's HRC met membership requirements in composition, self-advocate members did not all attend a majority of the meetings (75%). The agency needs to encourage and promote attendance of all mandated membership, including self-advocates. | | **Process Utilized to correct and review indicator** | | Reviewed importance at monthly Quality Assurance (QA) meetings. Worked with teams to determine additional self-advocate members. | | **Status at follow-up** | | Next HRC meeting is scheduled for 1/2022. New members plan to attend that meeting. | | **Rating** | | Met | |  |  | | |  | | |