

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

**Provider:** UCP of Western Massachusetts,  
 Inc. \_\_\_\_\_

**Provider Address:** 208 West Street , Pittsfield  
 \_\_\_\_\_

**Name of Person** Jennifer Summers  
**Completing Form:** \_\_\_\_\_

**Date(s) of Review:** 05-OCT-23 to 09-OCT-23  
 \_\_\_\_\_

<b>Follow-up Scope and results :</b>		
Service Grouping	Licensure level and duration	# Indicators std. met/ std. rated
Employment and Day Supports	2 Year License	5/5

**Summary of Ratings**

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

<b>Indicator #</b>	L56
<b>Indicator</b>	Restrictive practices

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<b>Area Need Improvement</b>	At both CBDS locations, locks were placed on the break room refrigerator and cabinets. There was no written rationale for this restriction pertaining to the health or safety of those attending CBDS or review by the agency's human rights committee. When an environmental restriction is necessary to protect an individual's health or safety, the agency need to develop a written plan that includes a rationale, less restrictive alternatives that have been considered, and clinical criteria for fading the restriction. In addition, the plan needs to be reviewed by the agency's HRC and incorporated into the individual's ISP. Additionally, plans to mitigate the impact of the restriction need to be developed for those individuals for whom the restriction is not necessary.
<b>Process Utilized to correct and review indicator</b>	Back in 2019, UCP went through the Council of Accreditation (COA) for National Certification. The qualifications that COA originally required regarding Early Intervention were changed and those changes were not shared with UCP during our recent re-accreditation. After our recent OQE Audit, as we were investigating COA requirements, we realized that this practice was no longer relevant.
<b>Status at follow-up</b>	UCP has removed all restrictions for breakroom refrigerators and cabinets to ensure the least restrictive environment for our members.
<b>Rating</b>	Met

<b>Indicator #</b>	L86
<b>Indicator</b>	Required assessments
<b>Area Need Improvement</b>	For one individual, required ISP assessments were not submitted to DDS within required timelines. The agency needs to ensure that required ISP assessments are submitted to DDS within 15 days prior to the individual's scheduled ISP meeting.

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<b>Process Utilized to correct and review indicator</b>	As part of the follow-up needed to ensure timely ISP assessments are submitted within the DDS required timelines the agency recently developed a new process. UCP determined that most ISP submittals were outside of the allowed timeframe. UCP became aware that one staff member was in charge of submitting all ISP documentation. As the number of members had grown within UCP, UCP determined a need for additional oversight and additional staffing to ensure compliance was being met. The 2 Assistant Directors of Family Support and the Program Manager of Supported Living were trained and have been given a roster of members they are responsible for regarding the oversight of ISP requirements.
<b>Status at follow-up</b>	Since the recent OQE audit, this multidisciplinary team approach has provided a more complete and comprehensive oversight of required HCSIS documentation.
<b>Rating</b>	Met

<b>Indicator #</b>	L87
<b>Indicator</b>	Support strategies
<b>Area Need Improvement</b>	For two individuals, provider support strategies were not completed and/or not submitted within the required timelines. The agency needs to ensure that provider support strategies are submitted to DDS within 15 days prior to the individual's scheduled ISP meeting.

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<b>Process Utilized to correct and review indicator</b>	As part of the follow-up needed to ensure timely ISP assessments are submitted within the DDS required timelines the agency recently developed a new process. UCP determined that most ISP submittals were outside of the allowed timeframe. UCP became aware that one staff member was in charge of submitting all ISP documentation. As the number of members had grown within UCP, UCP determined a need for additional oversight and additional staffing to ensure compliance was being met. The 2 Assistant Directors of Family Support and the Program Manager of Supported Living were trained and have been given a roster of members they are responsible for regarding the oversight of ISP requirements.
<b>Status at follow-up</b>	Since the recent OQE audit, this multidisciplinary team approach has provided a more complete and comprehensive oversight of required HCSIS documentation.
<b>Rating</b>	Met

<b>Indicator #</b>	L88
<b>Indicator</b>	Strategies implemented
<b>Area Need Improvement</b>	For four individuals, the agency was not documenting progress on ISP goals. The agency needs to ensure that progress on ISP goals for which the agency is responsible is being documented consistently for all individuals.
<b>Process Utilized to correct and review indicator</b>	The Family Support team reviewed the case notes that were submitted for documenting the ISP goals. The Team determined the goals from the ISP had not been submitted to ICentrix (UCP database) and thus staff could not track the necessary documentation. Not all goals were missing for all members, but enough to cause a review of our process.

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<b>Status at follow-up</b>	With the addition of the ISP Multidisciplinary team, as described in L86/87, there has been continued and better oversight of ISP goals to the agency database (ICentrix). The Assistant Directors of Family Support are also reviewing case notes since the audit to ensure timely documentation of goals. This platform is accessible to all direct care staff working with specific members prompting staff to document whether the member is consistently working on their designated ISP goal(s).
<b>Rating</b>	Met

<b>Indicator #</b>	L91
<b>Indicator</b>	Incident management
<b>Area Need Improvement</b>	One incident report was not completed within the required timelines. The agency needs to ensure that all incident reports are completed and reviewed within the required timelines.
<b>Process Utilized to correct and review indicator</b>	Review of the incident report identified that staff that completed the incident report did not understand the difference between date of occurrence and date of discovery. It was also discovered that the necessary oversight from the supervisor was cursory.
<b>Status at follow-up</b>	The leadership of the Family Support Department was able to provide additional training to all staff that access HCSIS on the timelines required. This particular incident was submitted the day of discovery, but staff put in the day the incident occurred. Training provided clarification on the difference in time stamps in the HCSIS report. The team also implemented a second review of all incident reports before submitting.
<b>Rating</b>	Met