

FY08 QA Reviews - Noted Deficiencies and Evidence of Correction

MT 0208.90.R2.03 WAIVER

Achievements - Review date 1/07/2008 (QIS K.G.)

Finding: A signed receipt and acknowledgment form for the corporation's internal grievance procedure was not present.

Correction: Both consumers and employees sign a receipt and acknowledgment form.

Finding: A concrete way for consumers and family members to be informed that choice of supported living staff is an option does not exist.

Correction: During the consumer's individual planning meeting staff satisfaction is discussed and if the individual is not satisfied with staff adjustments are made. Also, through-out the year if consumers are having difficulties with certain staff members either the case manager or the consumer can initiate a change.

Finding: Flower Creek group home fire drill documentation did not indicate nocturnal drill completion. (QAOS dated 12/07/2007)

Correction: Staff are required to use a manual lift for 3 individuals in this home and policy states that staff not manually transfer or lift non ambulatory individuals except in the case of an actual fire. A letter was sent to the Libby Fire Department Marshall asking for help in developing a better protocol to address the lack of nocturnal drills.

QIS Follow-up: The administrator sent two letters to the fire marshall and just received a response in December. The administrator is currently working on purchasing cots to evacuate non-ambulatory individuals.

Finding: Montana Avenue group home conducted fire drills in which 4 out of 8 drills lasted longer than 4 minutes (best practice indicates 2.5 min.)(QAOS dated 12/07/2007)

Correction: A letter was sent to the Libby Fire Department Marshall asking for help in developing a better protocol for evacuation as well as addressing deep sleep drills.

QIS follow-up: The drills lasted longer due to non-ambulatory individuals; the purchase of cots should allow timely evacuation.

Finding: At the Green Springs apartments documentation in August indicated that two individuals refused to get out of bed to evacuate for a fire drill. In June another consumer needed prompting to evacuate. (QAOS dated 12/07/2007)

Correction: Special IP's will be conducted for those individuals listed above and training programs will be developed.

Finding: PRN medication protocol needs to be individualized and not a blanket form used for everyone. (QAOS dated 12/07/2007)

Correction: New OTC form was obtained and modified and will be used with each individual at their annual physical.

Finding: LPN's not initialing vital readings in medication administration logs. (QAOS dated 12/07/2007)

Correction: Provider will assure that all LPN procedures and medication administration is initialed appropriately.

Finding: A second signature on Medication Administration Logs was missing and is a requirement for Medication Administration. (QAOS dated 12/07/2007)

Correction: The provider has suggested that medication training will be conducted as part of quarterly staff training.

Finding: Refrigerator and freezer thermometers existed in some places and not in others and worked in some places and not in others.

Correction: This has been corrected.

Finding: A noted trend existed in terms of IP's not having functional or person centered goals and matching, meaningful objectives. Also plans having goals without objectives tied to them and dates that plans would be implemented which were not. (QAOS dated 12/07/2007)

Correction: Provider will develop "cheat sheet" to be used during the pre-IP and IP process to help address a number of areas. It will also be important to include the individual and staff who work with the individual in the pre-IP process to offer ideas for goals and objectives.

QIS follow-up: This is happening now.

Finding: The hot water temperature at Montana Exposure was documented to be 140 degrees. This is necessary for the silk screening that occurs, but concern for present for individual safety.

Correction: Still working out this issue, researching different hot water heaters, etc.

AWARE, Inc. - Region 4 and 5 Children's Intensive Family Education and Support Services - review date 1/03/2008 (QIS BJ, JM and PS) No significant deficiencies noted.

AWARE, Inc. - Region 3 Case Management Services - review date 3/07/2008 (QIS SM, and MK) No significant deficiencies noted.

Big Sandy Activities - Review date 5/22/2008 (QIS CW)

Finding: There is no written grievance procedure and it is not reviewed at least every six months as stated in the ARM. (QAOS dated 5/22/2008)

Correction: The personnel policy was amended to add individuals in service.

Finding: Water temperature was 124 in the co-ed home. (QAOS dated 5/22/2008)

Correction: The same day as the review the temperature gauge was adjusted.

Finding: A bathing protocol was not posted for a woman in the women's home that has seizures. The protocol was posted in the PSP book, but did not state that staff needed to be present during bathing.

Correction: The protocol was corrected and posted before reviewer left the site.

Finding: PRN protocols need to be updated as the form presently states that a rectal exam is necessary prior to giving constipation medication. (QAOS dated 5/22/2008)

Correction: The agency stated that this was not being done and removed the statement from the protocol.

Finding: Upon staff interview survey one staff stated that a consumer is sent to his room when he becomes upset. Upon further prompting the staff did not know what a behavioral protocol was. (QAOS dated 5/22/2008)

Correction: A mandatory staff meeting was held and the consumer's behaviors were discussed. An employee protocol was written that listed consumer's behaviors and a list of things that lessen the stimulation for him. A behavior specialist was also hired to assist with the preparation of behavior protocols.

Blackfeet Opportunities - Review date 4/17/2008 (QIS CK)

Finding: BOI has had repeated computer crashes disabling Incident Management and College of Direct Support, both contract requirements. (QAOS dated 4/17/2008)

Correction: Agency obtained new computer and central office staff are reloading the incident management program. All staff but one completed the College of Direct Support and the last staff person will have it completed shortly. Staff are also working with central office staff to develop a back up plan.

Finding: Transportation policy not implemented in its entirety. Vehicle maintenance schedules and monitoring unavailable and some transportation logs on the truck were unavailable. (QAOS dated 4/17/2008)

Correction: BOI developing a vehicle maintenance log for all vehicles. Mileage logs will continue to be used.

Finding: Since November, 2007 trend reports have not been generated because BOI's computer crashed. (QAOS dated 4/17/2008)

Correction: New computer was obtained and central office staff was asked to re-load incident management program and also asked to assist in developing a back-up system. All missing data will be reentered.

QIS follow-up: IM trends are now being generated monthly.

Finding: Two consumers did not have the grievance procedure reviewed with them at all and all others had one review yearly when twice yearly is required.

Correction: BOI will continue with grievance procedure and document all consumers twice a year. Staff will update two consumers and document immediately.

Finding: PSP data collection, implementation and quarterly/monthly review information was unavailable on individual. (QAOS dated 4/17/2008)

Correction: Documentation was misplaced with staff turnover. Since the review data was recovered and current staff is documenting data for PSP.

Finding: Group home did not have activities of daily living assessments for consumers served and supported living individual did not have an assessment. (QAOS dated 4/17/2008)

Correction: BOI developed new ADL assessments as well as consumer satisfaction surveys which are utilized and present in all files.

Finding: Two vehicles did not have fire extinguisher and third vehicle was not available for inspection. (QAOS dated 4/17/2008)

Correction: Fire extinguishers are present in all vehicles and are recharged annually. Extinguisher inspections will be documented on maintenance logs.

Finding: Staff survey questions were not all answered accurately. The areas that require additional training are in abuse/neglect, behavior interaction and assisting with medications. (QAOS dated 4/17/2008)

Correction: BOI staff is currently trained on a regular basis with minutes on file. Staff are attending Problem Solving training. Staff have also attended training with Mary Meise on interacting with consumers who have behaviors and preventive measures. In staff meetings staff are trained in assisting and updating medications. Prior to new medications being administered staff are trained.

CARE, LLC - Review date 6/17/2008 (QIS CM) No significant deficiencies noted.

Choteau Activities - Review date 5/14/2008(QIS LW)

Finding: Low mileage medical trips do not appear to be logged and billed to Medicaid. (QAOS dated 4/28/2008)

Correction: Denial letters were found due to Choteau Activities being so close to medical facilities. A consumer would have to make 19 medical trips per month in order to bill Medicaid. Agency will monitor and bill when appropriate.

Finding: Some incidents initially identified as critical may have been appropriately downgraded to reportable based on additional information however, this could result in trend analysis criterion not matching in a statewide review.

Correction: All incident reports initially classified as critical will be entered into database as critical.

Finding: MANDT certification was expired for several staff. Dates of expiration were recent (3/29 to 4/19). (QAOS dated 4/17/2008)

Correction: MANDT trainers will schedule classes enough in advance of expirations to allow for rescheduling if needed. More classes will be scheduled to avoid too many staff with same expiration date.

Finding: New forms for data collection were miscopied showing incorrect dates. Also, not all data sheets contained the year of service. This was a finding in the last review and was corrected.

Correction: Memo put in daily log book requesting that staff check the data sheets each day to ensure correct information is included.

Finding: Data in the form of checklists need to note supporting documentation as related to the action or service provided in the PSP.

Correction: 4 staff attended the PSP documentation training July 9, 2008.

Clark Bus Service - Reviewed 11/15/2007 (QIS MK) No significant deficiencies noted.

COR Enterprises - Reviewed 10/26/2008 (QIS SM) No significant deficiencies were noted.

DEAP - Reviewed 2/25/2008 (QIS KK)

Finding: 2 staff were not medication certified and had signed off on medications in the group home. (QAOS dated 2/19/2008)

Correction: Director will request an updated list of medication certification dates. Notice of expiration will be given at least 3 months in advance and a test date will be set at least 2 weeks prior.

Finding: The main bathroom upstairs at Sky Reach Group Home was in need of major repair. (QAOS dated 2/19/2008)

Correction: Bathroom is old and difficult to upkeep. In the process of completing. Maintenance man is completing price comparisons. Project will be complete within 9 months.

Finding: The window crank in bedroom that 2 consumers share at the group home could not be opened.

Correction: Purchased all new window cranks.

Finding: A Supported Living consumer was asked to test a smoke detector and it did not have a working battery. He was also not able to easily access his smoke detector. (QAOS dated 2/19/2008)

Correction: Safety checks will be assigned to full time permanent employees and not part time habilitation aides.

Finding: Sky Reach group home staff was not First Aid or CPR certified. (QAOS dated 2/19/2008)

Correction: Director will coordinate with another agency to get courses completed. Contact will be made by March 6th and training scheduled within 60 days.

Finding: In interviewing group home staff it was discovered that 2 staff did not know where to report suspected abuse, neglect or exploitation. (QAOS dated 2/19/2008)

Correction: Staff is trained annually. Will provide training more frequently. An in-service has been scheduled for March 5, 2008.

Easter Seals - Reviewed 1/09/2008 (QIS CK)

Finding: The grievance procedure is only documented as reviewed yearly instead of every 6 months. (QAOS dated 1/03/08)

Correction: All team leaders are aware of the requirement to review the grievance process every 6 months with each client. A bi-annual review will be added to the documentation checklists with implementation to be effective immediately.

Finding: Some staff surveyed were uncertain about abuse reporting requirements and behavior interaction with individuals. (QAOS dated 1/03/08)

Correction: Team leaders will do training on the general reporting requirements including reporting to APS, DDP and internal reporting procedures. The phone numbers for APS and DDP are posted and located in desk manuals; team leaders will ensure that all staff know where the numbers are and how to report. Team leaders will also review general guidelines for interacting with clients, for stepping in to protect clients in situations where potential or actual harm occurs and for dealing with specific clients if established protocols are in place for individuals in the service area. Team leaders will provide training sign off sheets for the training file and individual team members will add this training to their own training log upon completion

EMI - Reviewed 6/25/2008 (QIS KK) *email sent 1/02/09

Finding: PSP actions not implemented as specified at Nolan Group Home. (QAOS dated 6/03/08)

Correction: Staff turnover occurred and acting manager had not checked status of PSP goals. Acting manager is now aware and will follow up. The residential Coordinator will also follow up on goals along with the habilitation specialist.

Finding: PSP actions not implemented as specified at Wyoming Group Home. (QAOS dated 6/03/08)

Correction: Manager stated that February was completed but not documented, March was not completed due to staff shortages and May was complete. Starting in July the

action will occur by the 10th of the month. The Residential Coordinator will also be monitoring to ensure actions are being completed and documented.

Finding: Actions not implemented as specified in the plan at Gordon Group Home. (QAOS dated 6/03/08)

Correction: Group Home manager and staff will receive counseling and increased checks of actions. Habilitation Specialist will continue monthly data reviews.

Finding: QAOS sheets number 6, 10, 13 and 16 are all about issues where an IP or PSP was not implemented as specified. This shows a lack of internal monitoring. (QAOS dated 6/03/08)

Correction: Residential Services Coordinator will keep a better schedule of PSP's and implementation dates assisted by the Habilitation Specialist.

Finding: In reviewing the documentation for monthly fire drills in Miles City and Glendive several months of documentation were missing. (QAOS dated 6/03/08)

Correction: In Miles City a manager's monthly task list was created to help remind managers of necessary tasks. In Glendive a checklist will be posted at the day program to keep track of fire drills. The two noted missing fire drills for Wyoming group home had been completed but paperwork was not properly distributed.

Finding: In reviewing medication logs in Miles City and Glendive it was noted that there were cases where staff signed off on assisting consumers with medications and not having a current certification. There was also a case where a staff had not been certified for 6 months and had assisted with over the counter medication several times. (QAOS dated 6/03/08)

Correction: Human resources will send a bi-weekly list of non-certified staff to post. They have also improved communication and provided reminders of upcoming expirations.

Finding: When reviewing medication records at Wyoming group home it was noted that there was not a PRN protocol for a pain medication. (QAOS dated 6/03/08)

Correction: Protocol was overlooked and will be written with the assistance of doctor's recommendation.

Finding: During staff interviews 6 out of 10 said they would report suspected abuse to their supervisor and did not know they were mandatory reporters. They also did not state that an incident report needed to be written. During the same interview staff were not aware of what a PSP was or where the information came from. (QAOS dated 6/03/08)

Correction: RSC will complete an in-service with Hab Specialists on the PSP process. All staff are reminded at Mandt and Abuse Prevention classes and in-services that they are mandatory reporters. They can call APS but are encouraged to use the chain of command. Incident reports are written at the time of the incident by staff or are directed by supervisor to do so. In future staff will be reminded that they are mandatory APS reporters and an IR needs to be written immediately.

QIS follow-up: EMI provides orientation for all staff beginning employment at our facility. The orientation covers the subject of mandatory reporting both when going over the personnel policy manual and also during abuse prevention training. The procedure for reporting suspected abuse or neglect includes the definitions of abuse, exploitation and neglect, who to contact with phone numbers. This covers both our Miles City and Glendive programs. Staff also receive yearly or more often, in-services on abuse prevention and the subject of mandatory reporting. MANDT also covers the subject of mandatory reporting by employees of EMI. Staff are able to contact APS directly (phone number posted in all areas) or inform their supervisor, who will report the incident. All staff members do not participate in the PSP process, but are informed that consumers have a yearly meeting to identify future goals and steps to reaching those goals. Group home managers and team leaders attend the PSP meeting and disseminate information to other staff members. The nature of the PSP process will be expanded on during future orientation training.

Finding: During the Box Elder group home visit three smoke detectors were tested and only one worked. (QAOS dated 6/03/08)

Correction: Batteries have been replaced since inspection and group home manager counseled on testing alarms and fire drills.

Finding: When staff were asked at Box Elder group home about bathing protocols they stated that two consumers had protocols, but the protocols could not be located.

Correction: Protocols had been removed and not reposted. They were retyped and posted.

Family Outreach - Review dated 1/15/2008 for Child and Family Services and Supported Living Services. (QIS BJ) **No significant deficiencies were noted.**

Flathead Industries - Review date 7/23/2007 (QIS KG)

Finding: PRN form does not include specific parameters for individual consumers. Also, documentation of PRN's is difficult to follow. (QAOS dated 6/25/2007)

Correction: The PRN medication list will be revised with a request to the doctor to note any limitations or restrictions that vary from the label. Medication sheets used to track the use of PRN's will be reviewed to eliminate confusion.

Finding: While looking at medication procedures at Kalispell thrift store there was inaccurate documentation on medication administration sheets. The medication sheet did not indicate which medications were being administered but staff were signing off. Also when interviewing staff at Columbia Falls thrift store it was discovered that staff does not pass on information to the next care provider when OTC PRN medications are given during work. (QAOS dated 6/25/2007)

Correction: A staff in Kalispell will be assigned to oversee the medication sheets and Columbia Falls staff will be reminded of the policy.

Finding: While conducting staff interviews a noted trend of three areas existed. When asked staff said they would contact their supervisors first versus calling APS. Several had a difficult time answering what an IP is based on and two staff were unable to identify how to evacuate a certain building and what to do if a problem occurred. (QAOS dated 6/25/2007)

Correction: 1. A memo will be issued indicating the procedure of how staff report suspected abuse.
2. A central person meeting with all staff who prepare for IP's was implemented about two months ago. This should help guide all individuals in a consistent manner in preparing for IP's and understanding what an IP is based on.
3. All facilities will review at the next staff meeting the procedures for exiting their facilities and what to do if there is a problem. This will continue to be reviewed through the year.

Finding: In reviewing fire drill documentation it was noted that on one occasion a consumer was forgotten in his room and on other occasions consumers had refused to either get out of bed, the shower, etc. (QAOS dated 6/25/2007)

Correction: The safety coordinator will review fire drill documentation and address problems individually through educational discussions or through formal training programs.

Finding: Although hot water temperatures did not exceed 120 degrees, evidence did not exist to support that sites regularly check hot water and maintain a log. Staff did not seem to be aware that they should have thermometer and should be checking the hot water temps on a regular basis. (QAOS dated 6/25/2007)

Correction: Group homes will purchase additional thermometers from those used in Supported Living to ensure hot water is checked regularly. Staff had indicated that this was not being done only because they did not have the thermometers. It was also suggested that they maintain a log to document monthly checks.

QIS follow-up: Thermometers were purchased, logs sporadically maintained, this years review revealed high hot water temps

Finding: Although each living sites had bathing procedures in place but they were not addressed in the individual's IP. (QAOS dated 6/25/2007)

Correction: Case Managers have a new health form which is filled out at each IP or prior to the IP meeting and will meet this requirement.

Finding: A noted trend existed in terms of IP's having functional objectives based on the wishes, desires and dreams of an individual as well as engaging in the activities of set objectives. (QAOS dated 6/25/2007)

Correction: There is now a central person who meets with all staff when preparing for an IP, emphasizing goals that help achieve an individual's long range goal and functionality.

Finding: While visiting the West North supported living site zero fire extinguishers were available on site. It was also noted that earlier in the year all extinguishers were removed from the site for servicing. They remained at the main building for quite some time prior to servicing leaving consumers at risk. (QAOS dated 6/25/2007)

Correction: In the future fire extinguisher servicing will occur at each site.

Finding: Gaps in service delivery were observed with a couple of consumers in supported living. One individual was supposed to attend boundaries training once a month and documentation did not support attendance for two months. Another individual had an objective to clean his house once a week and there was missing documentation that this was occurring. (QAOS dated 6/25/2007)

Correction: The provider believed this to be a documentation issue with newer staff. Continued Quality Assurance checks by the QA Coordinator. In addition to Hab Tech II and other staff will be reminded to review program books monthly.

Finding: Not all day service sites locked dangerous cleaning chemicals.

Correction: Locking cleaning chemicals was mentioned in this year's review Throughout the year I did not identify a time when cleaning chemicals were not locked, however during this review one thrift store did not lock cleaning chemicals.

Finding: A rights restriction for a consumer did not include a plan for reducing the need for the restriction. (QAOS dated 6/25/2007)

Correction: The provider implemented a plan immediately and the consumer is currently on step 1. The program will be reviewed at the annual meeting.

Finding: While conducting the review of the 3rd Ave group home it was discovered that individuals did not have a concrete way of choice regarding leisure/recreational activities/ or integration into the community. (QAOS dated 6/25/2007)

Correction: Consumer meetings are required on a quarterly basis and show a great deal of discussion and choice by the consumers. When planning the monthly recreation calendar staff and consumers will review the past meeting to help ensure consumer's choices are included.

Glen-Wood, Inc. - Review date June 30, 2008 (QIS SC)

Finding: At the group home and Work Activity Center evidence was found indicating a lack of internal monitoring of IP actions/objectives. At the group home, a

current year IP for one individual could not be found. Gaps in service delivery are evident. Data collection was not consistent. Data systems are not organized and are cumbersome.

Correction: The missing IP was located and placed in folder at the group home. At the Work Activity Center training programs are color coded by frequency. If a program is to be run 3 times a week there are 3 blocks color coded yellow. When the program is completed staff initial. If not completed an X is put in the box and another box added to meet the frequency. Supervisors check frequency sheets each day prior to staff leaving.

Finding: Two group home individuals had specific objectives for staff to assist them in communicating with family/friends. There was a lack of evidence that this was occurring.

Correction: Communication programs are being reviewed for all facilities at an all staff meeting. Data will be closely monitored and reported on monthly summaries.

Havre Day Activity Center, Inc.- Review date 8/30/2007 (QIS CT and CK)

Finding: Background checks were not available for employees hired prior to 2001. (QAOS dated 8/20/2007)

Correction: Background checks were completed on 12 staff in June, 2007 and are available for review.

Finding: Grievance procedure only explained upon entry into services and not every six months. (QAOS dated 8/20/2007)

Correction: Each group home's lead trainer will review the grievance procedure with consumers in September, 2007 and every six months there after.

Finding: There is no policy or documentation showing that supported living consumers and or families have a choice in staff. (QAOS dated 8/20/2007)

Correction: At least one consumer will be present at interviews from now on with the consumer's name added to the questionnaire and kept in the employee's file.

Finding: On two occasions at Blvd Group Home medications were found to be unlocked. Medication procedures are not consistent from site to site. (QAOS dated 8/20/2007)

Correction: Starting in September, 2007 and at least every six months after Havre Day's medication policy will be reviewed with all staff.

Finding: A trend was identified showing staff being unaware of individual behavior protocols. Staff stated a belief that there were rights restrictions in place that were not and being unaware of behavior protocols that were in place. (QAOS dated 8/20/2007)

Correction: All behavioral and medical protocols and right's restrictions will be reviewed at staff meetings on a quarterly basis. Also, new staff onsite training will include this information.

Finding: Consumer had a physician's order to put Vicks Vaporub on his feet nightly to treat his foot fungal infection. He was given the Vicks every night, but staff were not supervising the application. The consumer also had a bathing procedure to have staff check to make sure he dries himself completely. These procedures were not followed and therefore no one could determine the last time the consumer's feet were observed. It was discovered at an appointment at the foot clinic that the consumer had a rash and edema and his toenails were in great need of being trimmed. A report was made to APS and four days later he was in the hospital for edema in his feet. APS found that Adult maltreatment was indicated for medical neglect. (QAOS dated 4/11/2007)

Correction: All staff have been retrained in the proper procedure for meds administration. They are responsible for the individual taking their medications regardless of how independent they are and they must also observe the individual taking the medication. Havre Day also stated in two other documents that they are implementing all other recommendations by APS and will document when clients refuse checks.

Hi-Line Home Program, Inc. - Review date 6/29/2008 (QIS SC) No significant deficiencies were noted.

J.O.B.S. - Review date 5/05/2008 (QIS SP) No significant deficiencies were noted.

Living Life, LLC - Review date 9/05/2008 (QIS CK)

Finding: DDP has repeatedly requested that Living Life collect and analyze data to assist them in assessing a specific consumer's behavioral needs. Data was produced for October, 2007 but nothing since. (QAOS dated 9/05/2008)

Correction: Living Life agrees that communication with DDP has been an issue and are trying to improve this. Data will be sent to the case manager and QIS monthly in graph form starting October 5, 2008.

Finding: Staff continue to have difficulties documenting detailed information on incident reports and via email and phone messages. (QAOS dated 9/05/2008)

Correction: Staff were trained on September 22, 2008 to leave more detailed information and supervisors are following up on written IR information if the information is not presenting a full picture. On going training with direct care staff will also continue.

- Finding: There are staff who have worked longer than 30 days and are not CPR certified. (QAOS dated 9/05/2008)
Correction: Living Life has implemented training one time per month to ensure that all certifications are current. If staff say they have the training but cannot produce documentation they will go through the training again. A supervisor will report on a monthly basis certifications and due dates.
- Finding: One individual reviewed safety check list did not reveal that the smoke alarms had been checked. (QAOS dated 9/05/2008)
Correction: Monthly data will continue to be recorded. Staff have been reminded to ensure that they record data at the time they complete any and all reviews.
- Finding: Staff did not answer adequately the steps that are to be taken if abuse occurs and what steps to take in an emergency evacuation situation of how to run a drill.
Correction: Staff will receive one-on-one training on this procedure and documentation will be placed in personnel file by October 1, 2008.
- Finding: Staff were not aware of 2 of the 4 rights restrictions of one consumer.
Correction: The consumer's team met and updated right's restrictions and currently have trained all staff as of 9-17-2008. Copies of restrictions are kept in the graphing book.

Mainstream Independent Living Services, Inc. - Review date 3/11/2008
(QIS BJ) **No significant deficiencies were noted.**

Malta Opportunities, Inc - Review date 6/30/2008 (QIS SC)

- Finding: MOI received a temporary group home license. Issues of deficiency include maintenance concerns in the bathroom as well as being grimy with mold and dust in the ceiling fan. (QAOS dated 5/30/2008)
Correction: Bathroom cleanliness/condition section added to group home monthly safety checklist that is completed. Caulk has been replaced as well as ceiling fan cleaned.
- Finding: MOI had rehired a past employee without conducting a new background check. (QAOS dated 5/30/2008)
Correction: On June 3, 2008 a new background check was conducted.
- Finding: All staff surveyed insisted on reporting allegations of abuse, neglect, or exploitation to a supervisor and that the supervisor is responsible for reporting to the appropriate agencies. (QAOS dated 5/30/2008)
Correction: Training on reporting requirements will be given followed by a test that must be passed with 100% accuracy.

- Finding: The group home was missing a fire drill for April, 2008. (QAOS dated 5/30/2008)
- Correction: Group home manager has been informed of fire drill procedure. Monthly reports will be forwarded to the executive director.

MOI was issued a corrective action March 26, 2008. The issues identified were staffing and staffing competencies and consumer health and safety. MOI is asked to design a plan detailing how they will provide adequate supervision of direct care staff to ensure health and safety of individuals served. Document who is responsible for implementing plans of care in the group home, day program and supported living. Describe how accountability will be established for those assigned responsibility for implementing plans of care. Define how they will assure individual's plans of care are followed and documented on a daily basis. Describe how they will assure medical needs are addressed initially and on an ongoing basis.

Action steps taken were:

1. Develop new med sheets which was completed 6/10/08
2. Instruct staff on medications and side effects - by 9/16/08 all group home staff but one had reviewed and WAC staff will be added for meds passed in that area.
3. Med policy reviewed by each staff - group home staff completed 6/13/08 and 7/29/08 completed by WAC staff.
4. Med policy in each MAR - When checked on 9/11/08 this was ok.
5. Med monitoring - completed by 8/22/08 with only one staff left. As of 12/18/08 all staff complete.
6. CDS-OJT med training - As of 11/12/08 materials were shared with GH manager and this will be an ongoing improvement project.
7. End of month review of med errors to executive director - 2 reports so far one each in July and August. As of 11/12/08 this is done and is shared with BOD.
8. Med error report reviewed by board of directors - was reviewed as per agenda 8/19/08 but minutes were not ready for review. As of 1/6/09 minutes show reviews each meeting.
9. Med policy amended - completed 6/10/08
10. Review med appointments/ health care checklists weekly and calendar kept for appointments - QIS reviewed agendas/minutes on 7/17/08 and not reviewing daily checklists yet but were reviewed when QIS checked on 9/11/08.
11. Med appointment sheets amended with cc: section - completed 7/10/08. When reviewed on 9/11/08 new med appt sheets were not being used. As of 11/12/08 Executive director was counseling hab Spec to use the current form and on the 1/6/09 review a new Hab Spec was hired and has made some changes on form to make it easier to use. Looks ok so far.
12. Med appointment sheets forwarded as needed - 9/11/08 only sent to family at this point. As of 11/12/08 sheets are being forwarded.
13. Comment section on med sheets filled in - on 9/11/08 this was being done.
14. GH schedule/assignment sheet for programs/rec and leisure outings - by 9/11/08 daily assignments being done.

15. Progress report sent to executive director by end of the week - weekly summary sheets being sent in.
16. Hab Specialist visit GH 2 times monthly, review books, help staff with technical assistance and address concerns of staff - As of 9/11/08 reports received and data is looking good.
17. Drop in visit sheet developed - completed 7/11/08
18. GH drop in visits done - this is being done as of 9/11/08.

MET Transit - Review date 11/05/2007

No significant deficiencies were noted.

Milk River, Inc. - Review date 6/12/2008 (QIS CF)

- Finding: PSP and IP plans were not readily available to staff in the Mitchell and Warren group homes. (QAOS dated 5/30/2008)
- Correction: From now on as each person has their new PSP the managers will hold a staff meeting and go through the new PSP with the staff. Staff will initial and date the document to show that they were trained. The PSP will be available on site for all staff.
- Finding: Objectives/Actions/Implementation Strategies from the PSP/IP were not implemented on time by the date prescribed in the individual's plan. This was evidenced by review of the program files at Mitchell and Warren group homes, TLC and the WAC. (QAOS dated 5/30/2008)
- Correction: The implementation strategies and actions have now all been implemented and are being reported on monthly so that this will not occur again.
- Finding: The data keeping systems did not reflect the current PSP/IP objectives, actions or implementation strategies in several of the program books reviewed at Mitchell and Warren group homes, TLC, and the WAC. Quarterly reports reflect this same information. (QAOS dated 5/30/2008)
- Correction: We were still in the process of sorting out what was old, what was new and what was no longer necessary in moving to the new PSP system. Data has now been combined and implementation strategies are all current.
- Finding: Mitchell group home medication Administration Records show that there are several times when only one staff's initials appear. Agency policy is that two staff sign.
- Correction: This was an old protocol that was removed from the books. The protocol has been updated and changed to reflect the current practices. (Check on what the current practice is)
- QIS follow-up: Milk River Inc.'s current practice is outlined in the agency's Medication Delivery Policy and Procedure; "Either the staff that is dispensing/assisting

with the medications or the individual that is taking the medication will initial the Medication Administration Record."

Mission Mountain Enterprises - Review date 6/30/2008 (QIS RH)

Finding: An individual did not receive the PT evaluation or wheelchair evaluation that was specified as a need in 2006 IP summary. (QAOS dated 9/04/07)

Correction: Consumer will have a PT evaluation this month (1-2008) along with recommendations for his new wheelchair. It was recommended by KalMed that consumer not have any evaluations until 2008 so that they were within their service period for the new wheelchair. There is presently a script for the OT evaluation which will occur after the PT recommendations and new chair have been purchased.

Finding: Programs are occurring less than specified in the IP. (QAOS dated 2/2008)

Correction: Group home manager has participated in intensive training in the completion of IP paperwork including writing programs and objectives and developing appropriate schedules for program completion. The current programs are being revised to allow for less staff error and more client participation. Procedures are also being put into place to monitor and track completion of program sessions on a weekly basis. Mission Mountain is also restructuring their management to make lead supervisors available in all group homes 7 days a week. This will be implemented in April, 2008.

Finding: Folks are not doing in-home leisure activities and community outings as specified in the ARM. (QAOS dated 2/2008)

Correction: When clients decline to participate in in-home leisure activities and community outings staff will record this as a refusal and attempt to modify activities in the future to increase participation of more clients. New procedures are also being put into place to monitor and track completion of in home leisure activities and scheduled community outings on a weekly basis. Mission Mountain is also restructuring their management to make lead supervisors available in all group homes 7 days a week. This will be implemented in April, 2008.

Finding: The IP assessment is not functional and therefore the IP is not based on functional assessments, wishes, desires and needs of the consumer. (QAOS dated 2/2008)

Correction: A list of preferred assessments was developed in collaboration with the QIS and will be used in the future. List of assessments included in document.

**Missoula Developmental Service Corporation - Review date 4/09/2008
(QIS DS)**

- Finding:** Concern that 26% of consumers did not attend their IP's in 2007. Reasons included guardian request and consumer refused. Also concern with direct care staff not attending IP meetings although they are consulted prior to the meeting. If the consumer cannot be at the meeting then the direct care staff absolutely has to be attending. In addition, it is not the guardian's decision whether a consumer attends the IP meeting. Every agency's goal should be 100% of their consumers attend their IP. (QAOS dated 3/24/2008)
- Correction:** Effective immediately MDSC will mandate direct care presence at annual client PSP meetings. MDSC will make all necessary accommodations to ensure the client is as comfortable as possible during their meeting. MDSC will work with case managers to make sure guardians understand that it is not their decision whether a client attends the PSP meeting or not.
- Finding:** During staff interviews staff did not state that Adult Protective Services needed to be notified in situations where abuse or neglect is suspected or observed. When reading through MDSC's abuse and neglect policy it was not clearly written that APS can be notified prior to any other notification of the agency. (QAOS dated 3/24/2008)
- Correction:** MDSC updated the Incident and Emergency Procedures on 1/01/08 and created the Incident Reporting Definition Quick Reference. The first part clearly states any actual or suspected abuse is required to be reported to APS ASAP and the phone number is included. On Monday April 14, 2008 the Director of Services will meet with all Program Managers to discuss the importance of this matter and copies of the Abuse and Neglect policy highlighting APS as the immediate contact and provide another copy of the updated MDSC Incident Reporting Definition Quick Reference. Program managers will discuss the process at staff meetings and the revised Quick Reference will be posted in all group home sites.

New Horizons Unlimited - Review date 9/24/2007 (QIS CT and JD)

- Finding:** The agency is urged to consider partnering with other agencies to ensure people at all levels of the agency get the best and most accurate information available. Likewise the agency is urged to develop better lines of communication within itself to ensure that it is operating as a Team toward a common goal. Documentation of staff and management team meetings should be kept.
- Correction:** NHU's executive director has been developing a working relationship with the ED's in Big Sandy and Malta. NHU has communication books that travel back and forth between the GH/SL and the DC with any pertinent information needed. NHU documents all meetings. Now that we have a SL program manager we will be conducting regular SL meetings that will also be documented. NHU will be conducting regular staff meetings at all sites as well as all staff meetings.

QIS Follow-up: NHU has been conducting weekly management meetings which have helped to improve communication. Management staff has been in contact with central office staff for assistance in billing and financial services. One all staff training/meeting was conducted in October and another one is scheduled for January. Improvement has been noted but needs to be a continued priority as was demonstrated by the incident with a client that resulted in APS findings of mistreatment and injuries.

Finding: NHU does not currently have a policy/procedure manual. Policies that are currently written are difficult to locate. Policies that were written during the previous corrective action were lost and not implemented. Many critical policies are not in place at NHU.

Correction: NHU has since put together a policy manual with all required policies.

Finding: NHU has struggled to completely understand the requirements of set out by state policy and through their contract. It has been recommended on numerous occasions that the executive director network with other area providers for support and information. Assistance is available through the regional and central office as well. (QAOS dated 9/10/2007)

Correction: NHU has learned to contact the proper people in the regional and central office. NHU's executive director has also been contacting various other agencies for help with different problems, issues or concerns. The NHU executive director is also in the process of reading completely through any and all state policies available and the 2007-2008 contract.

Finding: A clear analysis of individual cost plans and their relation to actual direct care hours being provided proved to be quite difficult during the on site review. Records of the direct care hours were inaccurate as non direct care employees were added into the total direct care hours recorded. Staffing patterns are inconsistent due to staff turnover and scheduling difficulties. (QAOS dated 9/10/2007)

Correction: New program managers have been hired and NHU will be conducting regular all staff meetings and weekly program manager meetings where all issues will be discussed. A trainer will also be hired who will do all training in Census Form requirements. The business manager has contacted another provider for help with proper recording, billing and invoicing of direct care hours. The QIS requested more detail as to the curriculum that will be trained for both census reporting, billing and invoicing. She is also requesting that census and on sight staffing documentation be sent into the DDP office with monthly invoices. This was completed for September and the QIS is requesting that October-December be sent as well.

QIS Follow-up: Additional information requested was sent and reviewed. Demonstrated much improvement in documentation

Finding: It was noted that a supported living consumer received only 71.5% of his ICP hours. Direct care hours were not provided consistently across the time period

and the consumer's behavioral reinforcement program was not being run. On July 10, 2007 this individual was being seen by behavioral health services after an aggressive outburst. (QAOS dated 9/10/2007)

Correction: NHU is implementing a new staffing pattern in regard to this consumer. Instead of one staff meeting all of his needs we are rotating staff, therefore avoiding problems of burnout. NHU also put together information on the consumer's disability that was shared with staff and training was obtained from Dr. Ralph Russell in how to help consumer avoid aggressive outbursts. The QIS requested additional information on specific plans to ensure that staffing is provided on a consistent basis for this consumer and all others and that programs are run consistently.

Response from NHU: NHU is currently holding weekly program manager meetings. Staffing issues and resolutions are discussed weekly as well as PSP implementation and documentation. Each program manager is checking to ensure their staff understand how to document, what to document and why it is important as well as implementation of the programs.

QIS follow-up: The QIS noted that the things implemented were helping with communication and staffing. She is still requesting staffing records for October-December. Information requested was sent and reviewed. Demonstrated much improvement in documenting hrs worked consistently

Finding: A medication administration procedure was written by the previous executive director as part of the previous corrective action plan. This procedure was misplaced and was not implemented. In the absence of a procedure medication errors have been high at NHU. There were 5 instances in 4 months of consumers receiving someone else's medications. Other errors included running out of meds over the weekend, consumers accessing meds on their own, and multiple refusals. Staff are inconsistent about calling for follow up advice from the pharmacy and/or physician after a medication error. (QAOS dated 9/10/2007)

Correction: The Medication Administration Procedure was found and has been implemented. A new procedure sheet has been written stating that in the event of a med error the pharmacy or physician must be contacted immediately and gives the phone numbers for each. Also adding a trainer for staff will help reduce med errors when proper orientation and training is implemented.

QIS follow-up: Medication errors have decreased greatly since the implementation of the med administration procedure. All medications were observed to be locked up. Staff have been consistent about calling the pharmacy for advice on how to handle refusals or missed medications.

Continued concerns: No staff trainer hired yet. Upon on-site review of the medication documentation books show that there are still blanks where medications were not signed off as being given in both the residential and day program books. Please provide staff training on medication documentation specifically when there is a refusal or missed medication. Provide documentation on this training.

QIS follow-up: Training documentation was sent. Medication errors had decreased due to implementation of new procedures.

Finding: PRN sheets were not current and no prescriptions were in the medication book. Most PRN's for pain or anxiety did not give staff objective indicators so they know when to give a medication. PRN documentation does not show antecedents or effects after the medication has been given. QIS did not see a medication count for narcotics to make sure there were no missing medications. Consumer has a Lidocane patch and staff did not know if this was a PRN or when she needed to have it. (QAOS dated 9/10/2007)

Correction: NHU has had 3 medication coordinators in a short period of time. The newest coordinator has updated all PRN sheets as well as prescriptions in the med book. All PRN's now give staff objective indicators so they know then to give the medication. Medication counts have also been implemented on all PRN's or any medications not in bubble packs. Consumers Lidocane patch is a PRN and there is now a PRN sheet for it.

QIS follow-up: All PRN protocols were available and had been updated. Doctor's sign-offs for prescriptions were not available and still need to be put in place. Also PRN protocols for the use of narcotics/pain killers need to be more specific so all staff can clearly recognize when it should be given.

QIS follow-up: PRN protocols were re-written to be more specific. Dr.s sign-offs were in place during the February review.

Finding: Training procedures and curriculum need to be implemented to thoroughly train staff in the areas of first aid and CPR, client rights, positive behavioral approaches, PSP writing and implementation, data collection, abuse prevention, confidentiality, incident reporting, and mandatory reporting responsibilities. Training in each of these areas needs to be formally addressed and documented. Annual review of this information needs to be conducted for all staff. (QAOS dated 9/10/2007)

Correction: NHU is in the process of implementing the College of Direct Support Training. NHU is also in the process of hiring a staff trainer. Also, Dr. Russell will be training on Positive Behavioral Approaches. Julie Anderson with APS will be training on abuse and neglect reporting responsibilities. The staff trainer will work closely with Dr. Russell and Julie Anderson to ensure that the proper training is given to all staff. The staff trainer will be responsible for annual review of all orientation and training requirements.

QIS follow-up: No further progress has been made in this area. Orientation and training of staff is extremely important for quality services and safety of people we support. Proper orientation is also a contractual obligation. Please provide a written plan of correction outlining the steps you will take to produce a training curriculum and have it implemented with dates for each step of completion. Please send updates weekly.

QIS follow-up: NHU has assigned the executive director as staff trainer. Orientation and training has been approved and implemented.

- Finding: A trend shows staff being unaware of individual behavior protocols. Staff also stated a belief that rights restrictions were in place that were not. Reinforcement program were not run as written. An overall culture of “parenting” the consumers was witnessed. Training should be conducted regarding positive behavior management techniques, client rights, and what constitutes aversive and abusive treatment by staff. (QAOS dated 9/10/2007)
- Correction: NHU Program Managers are now conducting orientation training including training on protocols and rights restrictions. NHU is in the process of hiring a staff trainer.
- QIS follow-up: No orientation and training curriculum has been produced to include specified items and no staff trainer has been hired. One day training was given to some staff on October 3rd, however a curriculum for training in these area needs to be implemented so all staff and new hires are adequately trained.
- QIS follow-up: Orientation and training has been approved and implemented.
- Finding: Program files of consumers reviewed as part of the QA process evidenced that programs are not being implemented as identified in the IP/PSP. This was evident in day services, group home services and supported living services. Two primary deficiencies were programs not run with the frequency specified in the objectives and documentation is sporadic and often incomplete. (QAOS dated 9/10/2007)
- Correction: Program managers are now in place. Staff turnover has slowed in recent months giving staff time to be oriented properly on PSP implementation. Weekly program manager meetings are held and program books are reviewed, holding managers accountable for documentation.
- QIS follow-up: Onsite review shows great improvement in this area. Only two actions were undocumented and it appeared that they did not have tabs and were just missed. Please add to your oversight procedures that the actions being documented match the actions in the PSP.
- Finding: Fire drill evacuation records show that a consumer has refused to exit fire drills. Although egress windows were installed in his bedroom he is not physically able to exit through his bedroom. (QAOS dated 9/10/2007)
- Correction: NHU is in the process of having steps built so the consumer can get out of the window safely. Program managers are also working on a program to help consumer learn to exit the premises safely.
- QIS follow-up: On site review shows progress for this consumer, but would like to see how the agency is handling this for all consumers they serve.
- Finding: NHU is currently not documenting weekly community integration activities. There is no record of recreational and leisure activities. (QAOS dated 9/10/2007)
- Correction: All PSP books now contain Rec and Leisure Logs and are being documented.
- QIS follow-up: On site review shows progress in this area, but more detail needs to be provided as well as the variety reflected that is actually occurring.

- Finding:** NHU does not have a policy and procedure on training staff who drive NHU vehicles and/or transport vehicles. A vehicles schedule needs to be written, implemented and documented to assure safe transportation of consumers. (QAOS dated 9/10/2007)
- Correction:** NHU has written a transportation policy and procedure. An all staff meeting is being held October 3, 2007. This policy will be reviewed and training will begin. Completion date for all staff being trained will be October 31, 2007. A vehicles maintenance policy and procedure has also been written and implemented and a vehicle maintenance schedule has also been implemented at NHU.
- QIS follow-up:** Transportation policy and procedures have been put in place and implemented. Staff have been trained and signed off on policies.

Opportunity Resources - Review date 3/18/2008 (QIS SP)

- Finding:** 4 critical incidents not reported to CM or QIS in DDP office. Current IP's and BP's not in file or accessible to staff. New staff unaware of individual's program and risks. (QAOS dated 8/4/07)
- Correction:** Agency did not respond and this issue is addressed again in QAOS dated 1/30/08
- Finding:** Double checks for August MAR not documented, 2 meds not documented as given and no daily wound check documented. Meds not being given due to lack of assuring the medication is available. Staffing ratio does not meet contract standard on 4 days in August. (QAOS dated 8/4/07)
- Correction:** Agency did not respond and this issue is addressed again in QAOS dated 1/15/08
- Finding:** At 8th street group home there is a lack of documentation demonstrating that actions and outcomes are being completed with consumers. At Dickinson Street group home documentation is lacking or indicates that consumer is not completing with no further follow up indicated. It was also noted that not all objectives were written in a measurable way. At the Benton apartments no data for topical medication on certain days. Objectives not implemented as written. Data sheets missing for some objectives. (QAOS dated 1/14 and 1/15/08)
- Correction:** ORI is in the process of implementing a program system that will involve daily tracking of program information through a new computer generated tracking system. Supervisors will be responsible for tracking and giving feedback to staff. The tracking system should be fully implemented by 5/1/08. ORI's staff development instructor will be training staff on the new system as well as writing measurable goals and objectives and writing individual program plans that are in compliance with DDP's IPP policy. This will also include data collection and maintenance of graduated goals.

Finding: During on site visit to Dickinson group home the medication administration log book was reviewed. There were several incidents of lack of documentation of assistance with medications and health care. (QAOS dated 1/15/08)

Correction: By April 1, 2008 ORI's medication policy and forms will be reviewed by the Services Committee and ORI's nurse to determine if there needs to be changes in the policy or forms and will be compared to what is taught in the College of Direct Supports medication support lessons and also compared with another Montana provider agency. At the Russell Street facility ORI has made a change to having one person in charge of medication supervision and another designated person assigned to do double checks. That person is also the back up if the primary person is unable to assist with medications. This has proven to reduce medications errors at the Russell Street facility. In the group homes ORI is going to limit the number of people involved in supervising medication assistance. The Hab Tech or shift supervisor will be the double check for their shift. The group home manager will be the person reviewing on a weekly basis to ensure that this coverage is being provided. My May 1, 2008 all staff will receive training in ORI medication policies and procedures and applicable College of Direct Supports components.

QIS Follow-up: This QAOS accepted with addition of MAR form amended to assure that documentation errors are tracked on the form and reported as medication errors.

Finding: The results of 8 staff interviews indicated that staff need additional training in the area of mandatory reporting suspected abuse, neglect and exploitation. This is evidenced by seven of eight staff responding that they would report to their supervisor when asked questions regarding mandatory reporting of witnessed or suspected abuse, neglect or exploitation. (QAOS dated 1/30/08)

Correction: In addition to the current methods for training staff, ORI developed with APS a series of trainings on signs and symptoms of abuse, neglect and exploitation as well as reporting. This is mandatory training for all ORI staff. An information sheet entitled "Detecting and Reporting Physical, Sexual, or Emotional Abuse" was developed and distributed. A second informational sheet was developed and posted in service sites throughout ORI.

Finding: There were consumers who did not have their IP/PSP within 365 days of the last meeting. (QAOS 3/4/08)

Correction: Annually, ORI case managers will send providers the proposed schedule for PSP meetings for the upcoming year. In the notifications that go out a statement will be included, "Please note that in accordance to PSP rule, this meeting has been scheduled within the mandated 365 days. Please take serious consideration of this mandate when requesting to reschedule."

Finding: Case manager not following the PSP process. PSP not complete and not distributed within timelines. QIS also informed by provider that CM is lacking in communication for pre-PSP prep. The team does not seem to be working together to meet the needs of the consumer. Several concerns have been

brought to the attention of the QIS regarding CM having a lack of knowledge of the DD system and procedures. This case manager's professionalism has been questioned by her co-workers and providers after being misinformed and causing unrest with consumers, family members, and direct care staff. (QAOS dated 8/22/08)

Correction: Initial PSP was delayed to 7/31/08 because case manager was out most of July due to illness and death of sister. Upon return to work an emergency referral was needed for another consumer whose health and safety were at risk in present residential situation. The meeting then did not occur on 7/31/08 due to unanticipated needs of the consumer. Additional meetings were held on August 13th and 20th. This consumer also lives in an area where the culture has not given much respect to time lines which does not clear the case manager of meeting deadlines, but makes it a challenge. In regard to training of case manager, a training program was proposed and approved by Tim Plaska of Central Office. MONA and PSP training were completed as well as 20 hours of shadowing other case managers. College of Direct Support courses will also be completed. The CEO of Havre Day expressed satisfaction with CM during interview.

Quality Life Concepts - Review date 6/6/08 (QIS JD, LW, CK, CW)

Finding: A med certified staff went to Riverview to pass meds and one consumer refused to take her meds which were then left for non-certified staff to pass. (QAOS dated 10-15-07)

Correction: Staff member received corrective action and was reminded that he must always follow policy/procedures and protocols.

Finding: Consumer did not receive medications for the whole day on 10/31/07. In reviewing the MAR sheet for 10-31-07 the 8 am meds were signed as given and the 8 pm meds were not signed for. It was also noted that one med was not signed as being given on 8 pm, 10-30-07. It was reportedly given and not documented. (QAOS dated 11-01-07)

Correction: Corrective action occurred with staff on 11-06-07 clearly outlining expectation for adhering to procedure anytime they assist with meds for clients. Retrain staff on procedures by 11-15-07.

Finding: 2 PSP's missing from files pulled to review. Staff did not know where they were. Looking at the daily interaction sheets, house logs indicate that programs are not being done. There is a +, -, R in the individuals books however this does not explain what the staff are doing with this individual. This is the same issue that came up in the 2007 comp. Eval QAOS 19. (QAOS dated 11/08/07)

Correction: Supervisor has been provided a specific time frame as to when these issues must be appropriately resolved. The Residential Services Supervisor (immediate supervisor) has been charged with discussing this situation and

making sure that all records, documents and other written materials meet requirements no later than December 7, 2007. Failure to meet this directive will result in serious disciplinary action.

- Finding: Recreation and leisure documentation was not present for Cedar so far this month. 1 recreational activity was documented which was a visit to the clinic. This is not a recreational activity. The next month that was located was for March, 2007. The house log and daily interaction sheets are lacking information. This concern was identified in the 2007 comprehensive evaluation QAOS 17. (QAOS dated 11/08/07)
- Correction: The supervisor has been put on notice on the need for immediate action regarding record keeping. Residential Services Supervisor has been directed to immediately follow up on all areas of concern with Residential Coordinator along with a specific timeframe for full implementation of required record keeping along with a letter reminding the person that is an area of critical need and appropriate disciplinary actions will follow if the areas are not brought up to agency and DDP standards. This must be completed no later than December 7, 2007.
- Finding: A consumer took 3 bottles of medications, Tylenol and 2 prescriptions - these were not identified in the incident report that was written. Medications were not secured as directed in the Managing Medications Manual page 11 and the consumer reported to staff afterwards what he had done. It was stated in the consumers transition plan from MDC that he be "line of sight close enough to respond" and medications should have been secured as a reasonable means of ensuring his safety. Consumer has a long history of suicidal ideation and attempts which have caused institutionalization in the past. (QAOS dated 1/22/08)
- Correction: PSP team will research a community commitment with consumer before he returns to services. This will allow QLC some additional options to completely secure his environment before he returns. A non-negotiable term limiting consumer's access to medications will need to be included in his treatment plan. Appropriate follow up will be initiated with staff for failure to follow medical orders.
- QIS Follow up: Please refer to Managing Medications Manual page 11 sub note 1. Keep all medications out of harm's way. Medication should be locked away from children and others who are not responsible. I am also concerned that the consumer has a history of suicidal ideation that indicate knives and medications as his primary means needs to be addressed to ensure his safety. I am concerned that a doctor wrote an order on January 14, 2008 wanting knives and medications locked up for safety reasons while hospitalized for another suicide attempt with no action taken. QLC also needs to address how they will keep the PSP team informed and alleviate the prolonged period of time it takes to respond to health and safety concerns.
- QIS Follow up: This client went to MDC where his suicidal ideation continued and he went from MDC to the Montana State Hospital.

Finding: Current career plans are not on file for consumers who have requested competitive employment. This issue has been raised during the last comp evaluation, was noted as a concern in the CARF report, repeated requests via email from DDP and CM have been made for consumer since August and no career plan is on file for DR. (QAOS dated 12/20/07)

Correction: Consumer's plan has been forwarded to his CM on 12/27/07. Other consumer's career plan has not been received from his CM. Email correspondence to the CM and QIS requesting the career plan was sent 1/03/08. QLC is meeting with DDP administrative personnel on 1/12/08 and is formulating plans to prevent reoccurrence.

Follow up from QIS: This is part of the agency corrective action plan currently.

Finding: On 1/19/08 staff reported that they gave a consumer another consumer's medication. The consumer passed out and spent the evening at the hospital as a result. Since October several medication errors have been noted. On 11/16/07 QIS and Program Manager talked at length about recent medication errors and what could be done to prevent them in the future. We discussed implementing a buddy system whenever possible and staff having scheduled days to assist and supervise medications. (QAOS dated 1/11/08)

Correction: QLC will redouble the corporate effort to avoid med errors to the greatest extent possible. QLC will continue to provide training to new and veteran staff members on the high importance of 100% compliance with delivery of medications at all times. A formal PA will be submitted to the Region II office by 2/01/08.

QIS Follow up: This is part of the agency corrective action plan. Medication errors continue to be an issue and are being monitored through CIC and the CAP.

Finding: As a result of QA follow up and CM QA review it was discovered that quarterlies have not been generated for 6 to 9 months out of the Conrad facilities. (QAOS dated 1/11/08)

Correction: Due to job requirements involving actual direct support care, supports to consumers both at the WAC and Skyline group home the quarterlies were not completed on a timely basis. The WSS will finish what is currently being required and once that has been completed he will provide quarterly materials from previous months. An Residential Coordinator is being hired for the Skyline group home to help alleviate issues.

Finding: Consumer was prescribed eye drops for high pressure in her eyes on 2/4/08. Prescription was not filled until 10:39 on 2/7/08. Eye exam was at 1:00 and at 5:00 form 47 reports insurance will not cover and Apothecary Drug is trying to get the doctor to allow a different medication. Staff reports that she will follow up on 2/5/08. It appears that a lack of communication and follow through played a role in this medication not being filled until the 7th. (QAOS dated 2/8/08)

Correction: QLC health and safety manager will follow up with Apothecary Pharmacy and reiterate the 2006 agreement as well as new request from QLC regarding payment for non-formulary medications by QLC on behalf of clients should the need arise. QLC will retrain on internal procedures for all Residential Coordinator's and Residential Services Supervisor's at Residential Coordinator meeting on 2/21/08 with regard to required insurance that every prescription be obtained to administer as prescribed.

Finding: Client was prescribed an insulin shot one time a day in the evening on 5/21/08. Client received the shot that day at the doctor's office. 5/22/08 RA, regional manager and QIS talked to staff about a nursing grant and possible options so client receives his shot. Regional manager suggested several nursing agencies or even the ER and let staff know that client still had to have the shot until the doctor changed or clarified the order. I talked to staff at 10:19 and 11:34 at which time it was reported that she was waiting for a phone call from the doctor to see if other alternatives could be used instead of a shot. We talked about different options such as sharing a nursing grant, walk in clinic, ER, staff to assist until a permanent plan could be arranged. Since the 21st the client has not had an insulin shot and no plan has been identified to ensure that he gets his medication. (QAOS dated 5/28/08)

Correction: Nursing grant was written per physicians order 5/29/08 because the doctor refused to try alternative methods to control the diabetes he gave the agency a few days to try and arrange treatment for the client. No nursing provider in Great Falls is willing to deliver this treatment daily. The physician has been called for alternatives since QLC cannot secure nursing support for this service to preserve the client's health and safety. All foods that he has eaten over the last week as much as possible will be submitted to the doctor in search for an alternative plan. QLC will send the Health and Safety coordinator to the site to ensure the meals provided are exactly what a diabetic needs to maintain his glucose levels at an acceptable level. Staff will record all intake of food and drink in an effort to monitor the client's food supplies. The team will continue to work on a plan of care for the client.

QIS Follow up: The team developed an alternate plan with diet and oral medication that is working for this consumer.

Finding: Communication issues remain that have caused consumers to miss important medical appointments, miss medications, miss potential service information, issues with Apothecary Drug and even timelines.

Correction: QLC has a procedure in place for client movement within the agency. All Residential Coordinators/Residential Services Supervisors will be retrained on the procedure by 8-01-08. Updates to computerized systems with MRDD Solutions are being explored. It is anticipated a computerized system will improve communications as well as supervisory accountability. QLC will produce on request for DDP any information pertinent to effective communication efforts.

This is being addressed through a corrective action plan dated January 1, 2008. QIS follow up is that as of 10/30/08 MRDD solutions not yet implemented. A plan of action is required.

Finding: It is important that the agency be able to show hours of support provided as outlined in the plan of care. Staff have reported confusion as to what to count as billable direct care vs administration. (QAOS dated 5/20/08)

Correction: QLC did implement a new system 5-01-08 for billing and tracking of employee hours to include direct care, administration, training, and use of PTO. Neither the CSS Director nor DAD Director was asked about this concern during the Comp Eval. QLC will produce upon request weekly tracking data for hours of services provided.
This is being addressed through a corrective action plan dated January 1, 2008. Agency reports that it just purchased a new system to track employee time per Lynn M. 10/29/08 by phone. A plan to assure that consumer needs by PSP and cost plan are met is still needed.

Finding: It is not clear whether the intent of the audit findings of two years ago have been met with regard to the writing of a fiscal manual that will serve as a training tool for anyone needing to pick up duties of the fiscal staff. Nor is it clear what progress has been made in the area of cross training staff to free up the fiscal director as a checks and balances person rather than the person who is responsible for all billing procedures. (QAOS dated 5/20/08)

Correction: Training has occurred – February 7, 2008 – 2 hours; March 4, 2008 – 5 hours. Fiscal manual is related only to client funds per audit. Client spending is part of our Policy A7, Procedures C4 and A5. QLC will be using information from our SSA audit in these procedures. This will be completed by August 1, 2008.

Finding: The agency has shown a nearly 34% decrease in reportable incidents. Additionally there has been an increase in client rights violations, use of mechanical restraints, and alleged mistreatment. (QAOS dated 5/20/08)

Correction: We believe there has been an improvement in program quality which is reflected in the data. However, we also believe that the data generated by Access grossly misrepresents the true number of incidents reported by QLC staff. This concern has been shared with local and State DDP. CIC will review the data generated by Access, in conjunction with a high risk review, to identify possible training needs and supports, to offer better services to our clients and staff. QLC implemented an alternate tracking system for medication errors, which is allowing management to identify areas of concern and implement training as needed. At this point there is no projected fix to the Access program. QLC will proactively take the necessary steps to analyze available data and implement necessary change.

This is being addressed through a corrective action plan dated January 1, 2008. A trending meeting was held on September 08. Follow up by IMC has been very good with data provided on a consistent and regular basis as to agency actions taken or still required. This issue is closed.

Finding: Each group home needs a written orientation process that is comprehensive and signed within the first week of working with the consumers. Additionally, the sharing of med certified staff has created errors when staff are not familiar with the people served. (QAOS dated 5/20/08)

Correction: QLC Residential Coordinators were retrained on 6-19-08 to orient all staff working in their homes per policy. Data indicates new inductees are completing a shadow shift at each location prior to their scheduled assignment. QLC has a monetary incentive for all staff every time they pass the medication test. New staff are given medication study guides in the first week of employment and encouraged to take the med test at their earliest opportunity. QLC offers study sessions, individual tutoring and mentoring sessions to assist them in studying for the med test. The agency will continue to support and encourage all staff to be medication certified. This is being addressed through a corrective action plan dated January 1, 2008. The agency continues to recruit staff and track whether med certified staff are available each shift/home. Med errors due to the pharmacy are still regularly reported, wrong meds/missed meds still seem to be a concern.

Finding: The healthcare checklist was not consistently available on each site as part of the PSP document. (QAOS dated 5/20/08)

Correction: On 6-19-08 QLC sent a written request to all case managers requesting current health care checklists for each client in services. QLC will document presence of health care checklist in each site on a quarterly basis using the new Residential Coordinator/Residential Services Supervisor site check list. QLC will implement a QLC checklist to double check contents of the PSP packets sent to the administrative office to ensure all documents are present for group home dissemination by 08-01-08. This is being addressed through a corrective action plan dated January 1, 2008. Site reviews October 2008 still showing missing HC checklists at site files. Sustain ability plan is necessary.

Finding: Data was not consistent in many sites. PSP's were not consistently available at all sites. There is no data for some of the consumers' actions. (QAOS dated 5/20/08)

Correction: QLC is looking to purchase computerized data system from MRDD Solutions to completely eliminate paper record system. It is anticipated a web based system for tracking which allows access at any time for DDP/Case Management/Agency supervisors is expected to be in place by 10-08. This is being addressed through a corrective action plan dated January 1, 2008. MRDD solutions not yet implemented. Actions still missing from PSP data as evidenced and verified on site from quarterly reviews. A plan is required.

Finding: PRN med procedures not available at all sites or did not document outcomes. Medication training programs were not found and PSP's did not always

document that the person had reached maximum independence. There was at least one occurrence of staff adding to the PRN protocol times to give the PRN that were not prescribed by the doctor or approved by the agency. MAR sheets were not always available. (QAOS dated 5/20/08)

Correction: All agency supervisors will be retrained on the required procedure by 08-01-08.

This is being addressed through a corrective action plan dated January 1, 2008. As of October 30, 2008 sites still missing some PRN's. Staff are very willing to fix the issue. Noted that some PRN protocols use the generic drug name while the MAR sheet and PSP use brand name or vice versa. Protocols also not updated. Oversight is required.

Finding: Not all sites had the grievance procedure posted or available. There was not consistent documentation that it was reviewed regularly or at 6 month intervals. (QAOS dated 5/20/08)

Correction: On 6-23-08 Residential Coordinators/Residential Services Supervisors were reminded during DDP/QLC Comp Eval review meeting of this requirement. New Residential Coordinator/Residential Services Supervisor quarterly checklist will allow for continued monitoring of this requirement. This is being addressed through a corrective action plan dated January 1, 2008. Will be reviewed at the next evaluation cycle. This does not appear as a line item on the Residential Coordinator/Residential Services Supervisor monthly review form.

Finding: Quarterly reports were sporadic and data on site didn't match what was reported in quarterlies submitted. Quarterly reports were non existent prior to January, 08. (QAOS dated 5/20/08)

Correction: Quarterly reports will be completed on a monthly basis. This is being addressed through a corrective action plan dated January 1, 2008. Has shown improvement in terms of reporting. Data indicates that not all actions implemented according to PSP. Reports are going out but it is not clear who is responsible for ensuring that appropriate action is taken where improvement is needed. CM's have asked in some cases repeatedly for program implementation when programs are missing.

Finding: During this review period two instances of potential breach of confidentiality were noted of concern. One involved a staff person upset with a client move who spoke to neighbors about personal information regarding the client. In a second instance a staff person had consumer files while on vacation out of state and they had to be mailed back to the agency. (QAOS dated 5/20/08)

Correction: Both staff involved in these incidents received appropriate action regarding this breach. The agency provides HIPAA/Client Confidentiality signed statements for all employees/employee handbook and periodic updates on client confidentiality. QLC will continue to train every employee on the requirement of confidentiality in order to attempt to preserve client information.

This is being addressed through a corrective action plan dated January 1, 2008. This QAOS is closed.

Finding: Bathing procedures were not posted in all sites. (QAOS dated 5/20/08)
Correction: Bathing procedures are posted in each bathroom as of 6-20-08. Residential Coordinator/Residential Services Supervisor checklist to be completed quarterly to ensure they are present.
This is being addressed through a corrective action plan dated January 1, 2008. Is evidenced on monthly Residential Coordinator/Residential Services Supervisor checklist procedures were posted and verified on site. This QAOS is closed.

Finding: Consumers did not have assessments on file to indicate their SL needs. Another consumer did not have work assessments to indicate his workday needs. (QAOS dated 5/20/08)
Correction: Assessments will be completed and kept on file.
This is being addressed through a corrective action plan dated January 1, 2008. This QAOS is closed.

Finding: In two group homes there were complaints by family and staff of consumers not being served 3 meals daily or not having adequate meals posted on site. While these issues were addressed at the time of discovery there have been additional trends and concerns with APS investigations that indicate there may be more client rights violations that have become part of the culture of the homes. (QAOS dated 5/20/08)
Correction: Abuse prevention will be retrained all All-Staff meeting in 7-08 by Staff Development Specialist. Residential Services Supervisors were trained on Roger MacNamara's Care Giving Assessment process in 06-08. Residential Services Supervisors will use this training as a tool to support direct care staff in implementing an empowering environment at group homes. Guardian parent advisory group invitations will be sent for meeting 07-29-08.
This is being addressed through a corrective action plan dated January 1, 2008. Menus were posted. This issue is being monitored through the IMC and incident reporting at this time. There have been additional client rights issues reported and follow up indicated that the rights restriction was not implemented. This seems to be an issue in two houses and may be an issue of specific staff but in both cases the staff involved are Residential Coordinator and setting an example for line staff. This could be addressed through more onsite supervision as is recommended in our summary review.

Finding: There was only one egress at the Two Times New store. The second was locked with no key available to staff. Additionally the Phoenix group home was to have a lighted strip to mark the step at the kitchen which was not completed. (QAOS dated 5/20/08)
Correction: Yellow paint strip provides a safe alert to staff and clients. A lighted strip is not feasible as no place to plug in an illumination strip, maintenance unable to

locate a battery operated strip. There is a ceiling light in the area at Phoenix group home to provide illumination at the site. Both doors at Two Times New will remain unlocked during regular business hours.

This is being addressed through a corrective action plan dated January 1, 2008. Back door was unlocked for egress on 10/24/08 and QAOS is closed.

- Finding: Sites had chemical/cleaning supply cabinets open. In some cases medication cabinets were found unlocked as well. (QAOS dated 5/20/08)
- Correction: Signs are posted on medication and chemical cupboards as a reminder for staff to keep them locked. New Residential Coordinator/Residential Services Supervisor checklist will monitor locked cabinets on a quarterly basis. Appropriate personnel action will occur when concerns of unlocked cupboards are noted. Residential Coordinators/Residential Services Supervisors were reminded of this requirement on 6-23-08 and the expectation for compliance was stressed. This is being addressed through a corrective action plan dated January 1, 2008. Chemicals were locked at sites surveyed October, 2008 and this QAOS is closed.
- Finding: Recreational and leisure logs were not consistently available at all sites. Additionally the PSP for recreational and leisure activities does not match the ARM for frequency offering less than the contract requirements. (QAOS dated 5/20/08)
- Correction: QLC is looking to convert all manual data tracking to computerized tracking with MRDD Solutions. It is expected that this will allow DDP/CM & Internal oversight of daily data so follow up can occur. All Residential Coordinators/Residential Services Supervisors were provided additional clarification during Residential Coordinator meeting on 6-19-08 of the expectations for rec/leisure activities and documentation requirements. This is being addressed through a corrective action plan dated January 1, 2008. MRDD solutions not yet implemented. This was noted in FY 07 and 08. Some questionable activities. Notes on PSP actions do not match ID notes. Oversight or plan to sustain is needed.
- Finding: Fire drills were missing at the QLC offices as well as several sites throughout the agency. (QAOS dated 5/20/08)
- Correction: There is a system in place for the health and safety manager to monitor drill requirements on a monthly basis. Health and Safety Manager will ensure complete compliance with requirement or per procedure, conduct the drills accordingly. QLC will add the administrative office to this monitoring system This is being addressed through a corrective action plan dated January 1, 2008. No concerns noted at this time and QAOS is closed.
- Finding: Low mileage medical trips do not appear to be logged and billed to Medicaid. (QAOS dated 5/20/08)

Correction: New procedure/data sheet for medical trips and billing requirements were provided to agency Residential Coordinator/Residential Services Supervisor on 6-19-08 by Fiscal Services. Billing for medical trips will be monitored by fiscal on an ongoing basis.
This is being addressed through a corrective action plan dated January 1, 2008. System was developed and was reviewed in August, 2008. Huge amounts of time to track but mileage not working out to be reimbursable. This QAOS is closed.

Finding: It appears from agency and department billing records that DDP and VR were both billed for supported work from Sept 07- March 08. The records indicate this appears to be true for SC and it is unclear if this occurred with other consumers as well. (QAOS dated 5/20/08)

Correction: Quality Life Concepts mistakenly was of the understanding that under a combination rate both VR and DDP could be billed. Monies paid under CSP for SC will be repaid to DDP by June 20, 2008. Internal policies will be reviewed. Check being processed June 17, 2008 and will be delivered via courier June 18, 2008.

This is being addressed through a corrective action plan dated January 1, 2008. No concerns at this time and QAOS is closed.

Finding: Several vans did not have fire extinguishers on board at the time of review. (QAOS dated 5/20/08)

Correction: Fire extinguishers were taken out to be re-serviced and not replaced. Agency staff did not accurately reflect the absence of a fire extinguisher in the vans per the monthly checklist. Beginning 07-08 the agency maintenance supervisor will do a quarterly check of every van to ensure all safety requirements are met on a consistent basis. QLC is in the process of contracting with a local fire extinguisher vendor. A more systematic process is being developed. QLC will be sure that fire extinguishers are included in agency van checklists and ensure that they are present and charged.
This is being addressed through a corrective action plan dated January 1, 2008. Fire extinguishers were noted to be on vans for houses surveyed and QAOS is closed.

Finding: Accessible ramp at the group home remains unsafe for anyone ambulating on it. (QAOS dated 5/20/08)

Correction: When clients moved into the house late in 2007 it was apparent that the front steps would be difficult for some to navigate. A ramp was installed from their previous home and a non slip surface was added to the ramp. Facility Maintenance has installed a new ramp with a landing just outside the front door. Handrails have been added as per ADA requirements. The non slip surface has been re-anchored and the bubbled surface is no longer there. The ramp appears to be quite sound and safe.

This is being addressed through a corrective action plan dated January 1, 2008. Conrad ramp repaired and secured and QAOS is closed.

Ravalli Services - Review date 6/25/2008 (QIS DS)

- Finding: RSC has not been able to meet the requirements of DDP's Incident Management Policy due to inadequate tracking procedures. (QAOS dated 6/30/08)
- Correction: RSC has signed on with Therap. Once additional computers are installed we will begin inputting data to bring the system online.
- Finding: In the WAC several files reviewed did not have data relating to the current objectives. Several individual's IP objectives could not be implemented due to broken equipment or missing supports. The objectives were not modified or new ones added. (QAOS dated 6/30/08)
- Correction: We have replaced staff in this area in an effort to shift the culture of the environment. We have reworked some of our programming and are in the process of implementing it. We have changed the look and feel of this area and are now attempting to enhance and refine the substance.
- Finding: Files in the WAC did not have updated information from the group homes regarding personal information. In addition, information was difficult to find due to being outdated. (QAOS dated 6/30/08)
- Correction: To remedy this situation I have hired a Quality Assurance Specialist who will develop and institute systems as well as holding individuals accountable. Once in place she will be charged with updating this information.
- Finding: During staff interviews most staff did not correctly address the procedures for reporting abuse and neglect. The majority of staff did not mention contacting APS or that they are mandatory reporters. (QAOS dated 6/30/08)
- Correction: I've spoken to HR and reviewed orientation information and this information is clearly explained to staff. During future staff meetings we will reiterate the responsibility we all have in this area.
- Finding: Review of fire drills revealed that the WAC and the Processing sites have no documentation of conducting fire drills. During interviews staff stated that they had participated in fire drills and were able to relate what the appropriate evacuation procedures were. (QAOS dated 6/30/08)
- Correction: The newly hired Quality Assurance Specialist will help bring us into compliance. I am also looking at carbon forms for a host of areas which may contribute to more consistent data collection.
- Finding: The annual review of the transportation and maintenance logs revealed months of missing logs. In addition, when questioned, staff could not adequately answer what follow up was conducted to ensure that repairs had occurred. (QAOS dated 6/30/08)

Correction: The carbon forms mentioned seem plausible as a way of ensuring that the information flows to multiple destinations. Copies will go to the business office for billing purposes and to HR for licensing.

Residential Support Services - Review date 3/17/08 (QIS DE)

Finding: During this review it came to my attention that early in 2007 Licensing had some concern about missing or undocumented drills. I would like copies of the correspondence that corrected this issue.

Secondly, in reviewing data for drill times 2 homes had several times at or above 10 minutes. These times seem too long, is there anything in writing at Residential Services Supervisor dictating what the cutoff is for an acceptable amount of time? If not, should there be?

Correction: This issue was addressed and resolved with Licensing some time ago, Residential Services Supervisor will forward correspondence between Licensing and Residential Services Supervisor. Residential Services Supervisor will work with safety committee to determine appropriate times, but without more overnight staff the times may remain the same. Will speak with Local Fire/rescue personnel to make better judgments regarding times.

Finding: Visit to Antelope II on 2/26/07 showed 1 staff for 5 clients for the evening shift. Previous ratio was 3:5 for the 4:00-8:00 PM shift. Individual cost plans allow for at least a 2:5 ratio which is needed to maintain health and safety. (QAOS dated 2/26/07)

Correction: Managers must double check before taking flex time.

QIS follow-up: Managers have been restructured in shift and duty as have the scheduled staff and as a result of this QAOS there have been no further ratio related issues.

Finding Off-peak staffing ratio at 20th St on 2/24/07 showed 1 staff for 7 clients. Consumer cost plans show 2 staff at all times other than overnight. (QAOS dated 3/5/07)

Correction: Residential Services Supervisor has taken a number of steps to increase staff. Wages have been increased for Hab Tech 1 positions and night staff as well as substitute staff. Residential Services Supervisor is also exploring the idea of hiring staff under the age of 18 for certain jobs. Last month Residential Services Supervisor spent \$4000 in recruiting staff. Residential Services Supervisor also floats staff between homes when necessary and Residential Services Supervisor administration have worked both weekends and weekdays.

Finding: On 9/21/07 a consumer was exercising on a treadmill at home. When it was time for her to stop, the staff accidentally turned the machine up instead of off and as a result the consumer fell and broke her humorous bone just below the rotator cuff. The staff was alone with 5 residents. Historically this home utilizes a ratio of 3:8. (QAOS dated 10/12/07)

- Correction: A decision was made to send a staff with 3 consumers into the community leaving 1 staff with the other 5 because another staff was coming on shift in less than an hour. Staff have been told that they need to stay within ratios in order to keep people safe.
- QIS follow-up: There have been no further ratio related issues since the QAOS from last year after restructuring the jobs of both managers and staff.
- Finding: On November 6, 2007 there was one staff on duty to care for 7 residents at 20th St group home. In discussing this matter with staff, a resident and a Case Manager it seems that this particular home has been left with single coverage on a number of occasions not identified in this correspondence. (QAOS dated 11/20/07)
- Correction: Discussed with manager the need to be available when other staff can not be found. Residential Services Supervisor administration will overhaul the way that scheduling is to be done and place greater control onto managers, managers will then work fixed shifts that allow for intervention when staff are not available.
- Finding: On November 16, 2007 a Case Manager visited Constellation GH at approximately 3:30 P.M. When she arrived there were 2 staff onsite. At 4:00 one of the staff announced that she had to be at a medical appointment and left, leaving one staff with 6 residents to prepare a meal, administer medications and contend with any unforeseen occurrences. (QAOS dated 11/21/07)
- Correction: Discussed at Incident Management meeting on 11/27/07. Residential Services Supervisor Personnel Policy (page 14) states, "LEAVING SHIFT: Staff will not leave their shift at the group home without approval of the administrative staff or the person on-call and the verification that relief staff will take their place on shift. There is absolutely no excuse for leaving the group home without permission while on shift. Failure to comply is considered neglect of duty and may result in immediate termination of employment." A support meeting has been scheduled for Constellation Home on Friday, November 30, 2007 to determine where communication could improve. Additionally, a Verbal Corrective action will be implemented with staff person regarding leaving shift while on duty.
- Finding: During the current review one staff from each of the sampled homes was asked a series of questions relating their jobs. The responses showed huge weaknesses in 3 of the 9 areas covered. 50% of staff asked about both "Abuse/Neglect reporting", and "Behavior interaction with Consumers" failed to respond appropriately. In addition almost 40% of staff asked about "Behavior support plans" failed to respond appropriately.
- Correction: Greater diligence in ongoing training at staff meetings, and the inclusion of CDS should reveal improved responses.

- Finding: In "Residential Services Supervisor Medication Policy 3/17/07" There are a statements that allow the pre-packaging of medications by a certified staff for the purpose of a non-certified staff assisting with those medications. Assistance in medications by an uncertified staff is not allowed. In the same policy it is stated several times that meds be given only by certified staff, and meds are not to be set up by one person and supervision provided by another.
- Correction: That language will be removed from policy IMMEDIATELY and the entire Residential Services Supervisor policy book will be rewritten during the coming year.

Resource, Support and Development, Inc. - Review date 11/8/07 (QIS MK and SM)

- Finding: An individual was screened into an intensive group home/day program/transportation as the alternate on 12/7/06. The transition was started but ended due to the need for more staff. Additional staff was approved on a temporary basis but the individual was only able to utilize his service one day per week at a day program. (QAOS dated 8/27/07)
- Correction: The family was offered the option of moving his money from the group home to SL to be provided by another agency and they turned it down. It is the agencies understanding that the family would like to transfer some of the residential funds to respite and to the day program if RSD is able to get staff hired there. There will be a wage increase of \$.50 to try to attract staff. The agency has been advertising since January 2007 for more staff. The agency also feels that they were not given accurate information on the individuals needs when he was screened in as the alternate.
- QIS follow-up: This individual has been being served full time with RSD residentially and in their day program. We continue to fund him 1:1 at this time,

Richland Opportunities, Inc. - Review date 6/13/2008 (QIS CF)

- Finding: An individual who previously worked for ROI was rehired without a Department of Justice criminal background check prior to being rehired. (QAOS dated 6/6/08)
- Correction: The employee had had this done less than a year ago so another one was not done upon rehire. After the QA a background check was completed and in the future they will be completed regardless of the timelines.

Spring Meadow Resources - Review date 6/30/2008 (QIS CM)

- Finding: On 6/15/08 an incident involving a client occurred which met the definition of "Reportable." The incident was not reported to the proper individuals within timelines specified in the policy. DDP first learned of the incident two days later when reported by another service provider.

Based on additional information received by the QIS, a voice mail message was left on the phone of the Incident Management Coordinator on 6/20/08 to elevate the incident to “critical” requiring an investigation. This was further discussed at the Incident Management Meeting; however no investigation report has been submitted to DDP.

Correction: Client was allowed to take out garbage, he made the decision to get into the dumpster to push down some garbage, and staff was unaware of this. He is not supervised while taking out garbage, as there has never been a need for it. It was an environmental hazard inside the metal garbage can.
He was informed to refrain from getting into the garbage can, which he agreed, I don’t believe this incident was a critical, as the cut below his knee was not deep enough for stitches at the time of the accident, after riding his bike and going to work and bumping his knee several times, the cut opened wider, he was taken to the doctor as soon as it was noticed, the physician stated maybe he should have had stitches but was too late after the injury. This injury did not require stitches when it first happened. Staff were unaware he injured it further until the next day when they checked it, but was immediately taken to doctor’s office. Judgment call was made by person who has been working with injuries and clients for over 30 years, her opinion was, that it was not deep enough for stitches. This was reported by voice message on Friday June 20, 2008. The message was not received personally until June 24th. The medical professional was given the report to follow up with, She had to contact the physician that saw the client, this took several days to compile the report. On July 8th, I received the report when I got back. I assumed she sent the report to the proper persons in a timely manner, as she is also an investigator; she actually gave it to me the Coordinator to review it first. I did not agree that this should have been upgraded to critical due to the original wound at the time of incident was not severe enough for emergency care. Staff will be trained to be more aware of timelines to DDP. If injuries are in question, follow-up with physician or ER will be required at the time of injury.

Finding: On 3/3/08, an incident of missed medication was written regarding a client. On Section 3—Incident Management Coordinator Review of the IR Form the IM Coordinator states “2nd med will be completed due to (consumer) not telling truth about taking meds.”
An Incident Report, dated 1/23/08, also reported a medication error for this individual. The Individual Plan for this person noted that she had not achieved maximum independence in administering her own medications; however no formal training program was in place. As indicated at the subsequent Incident Management Meeting, SMR decided to keep the individual’s medications in another person’s apartment so the client would take her medications with staff present. It was discussed at the IM meeting that this was not an acceptable long-term solution, however a compromise was agreed to, for a short period time, allowing the meds to remain in another individual’s apartment to give the provider time to devise a secure medication storage area in the client’s

apartment, revise staff scheduling and to develop training and data collection strategies for the client to learn to be independent with her medications in her apartment. At the IM Meeting on 2/8/08 the Incident Management Committee was informed that the Supported Living Department of SMR was still working out the details to implement a formal skill acquisition program. As of 3/14/08 had moved the client's medications back to her apartment, but had not implemented a formal skill acquisition program, nor had staff schedules been revised to assure staff were present to assist the client with her medications at the prescribed times.

Correction: Consumer's meds were found in a closet hid from the staff in an extra med container; previously she had graduated the med admin program when she moved into supported living. When this was discovered, a decision was made to move her medications to another area where she would have to come get her meds from a supervisor daily to ensure her meds were being taken. The QIS and the case manager did not like this idea, so another plan was developed. SMR asked to have a few days to come up with a better solution. Within 3 days on 3/4/08, her meds were taken back to her home, with a med protocol set up. Task analysis was developed for her to follow daily. Staff was questioned in a meeting about this; Staff took QIS to her office and gave her the written protocol and TA. There were no problems with it. In the original IP the previous year 2007, it was stated the client is independent in taking her medications on her own. It states in the QIS report that it states she had not achieved maximum independence which is a false statement. I can provide the documentation to show it stated she is independent in taking her medication. This was approved and signed by all team members including the case manager. The form 14 that is to be completed in the IP was already completed when we got into the IP, as this is common practice with this case manager, so I was not aware that she noted in her form 14 that the client was not independent.

The TA was implemented on 3/14/08; on 3/27/08 QIS was at the client's home to ensure the program was there and in place.

During her annual PSP, the program was talked about, it was suggested that her mother get her a talking med container to remind the client to take her medications at a specified time, To date there is not a working talking med reminder in the home. TA is being followed until mother complies with the PSP agreement for med reminder. Problems occasionally occur when she is with her family; they do not always ensure her meds are taken correctly. Protocols and TA are in place and are available to view at her home or in main office. Daily med checks are being completed by med certified staff. Staff do not sign for her medications on her medication sheets. TA will continue until 100% accuracy is achieved. SMR is not responsible for obtaining the talking med container, as this was agreed upon in the PSP meeting, mother would be responsible. The client is following her own protocol with only minimal verbal reminders for reporting step in her TA.

Finding: In recently reviewing Spring Meadow Resources' policy of "Abuse, Neglect and Exploitation of Persons Served" it was discovered that the policy does not comply with reporting requirements detailed by the State of Montana.

Correction: The policy had been in effect for a long time and had been passed by reviews from our Board of Directors and "CARF," and was thought to be in compliance with the state regulations on reporting. However it had been brought to our attention that the policy did not comply with reporting requirements

At the SMR board meeting on May 27th 2008, a revision of SMR policy was accepted. The new policy states that "Anyone who observes or suspects abuse/neglect/exploitation MUST report immediately to APS and supervisory personnel.

Finding: While reviewing staff log entries pertaining to one consumer it was discovered that his rights were violated without allowing him due process. No formal behavioral support plan or approved rights restriction is in place for this individual.

Correction: Questionable rights violation due to poor staff documentation. Examples of questionable rights violations and poor documentation. Examples are as follows: On 4/3/08 Documentation in log book stated "Client needs to be reminded to behave if he wants to have his birthday" The word party was not included in this statement. It should have said Client needs to be reminded to behave if he wants to have his birthday PARTY. The birthday party is a privilege not a right, therefore there was not a rights violation. 2nd example- On 10/27/07 Staff documented " Client has a teabag in his pocket and refuses to give staff, therefore staff locked up the teabags". This was not a rights violation as these teabags were not the client's, they belonged to another consumer. The client had no right to the teabags to begin with as they were not his property. On 7/19/08 Log book states " Client sneaked coffee and was confronted by staff" Poor documentation in this statement is evident, The client actually stole a cup of uncooked coffee grounds, not coffee that was actually drinkable. If he wants to buy his own coffee he has the right to do this and use it for himself. This coffee was coffee to be used for all the consumers. On 5/17/07, found documentation of possible right violations per QIS, This was not in the annual year, should have been questions in the previous year by QIS. Although this statement was made due to team decision, therefore no rights violation. There are other instances within this report that fall into previous years (back to 2005) that QIS has questioned and highlighted. These are issues that have been dealt with outside of the annual yearly report of 2008. We do recognize there are many documentation errors and will further training to ensure all log statements are understood fully.

Training has being completed for the second time; all staff will be trained and will sign off when training is complete. All new staff will be trained in NET training. Training will be completed in all aspects in all areas by the end of August 2008, Documentation training will be ongoing.

- Finding:** While conducting an on-site visit at Group Home on the evening of 5/30/07, I reviewed one individual's medication sheet in the Med Log and gathered information on staff assisting the consumer with her medications during the month of May. In comparing staff names with medication certification records the following morning, it was discovered that 4 staff assisting the consumer were not currently med certified. The Assistant Director for Spring Meadow Resources was immediately notified of the finding (Group Home Manager, Residential Services Specialist, Operations Manager, and Quality Assurance/Training Coordinator were not available). In talking with SMR's Quality Assurance/Training Coordinator later in the day it became apparent that at least one individual was aware her certification had expired, but none the less continued to assist consumers with their medications.
- Correction:** SMR staff failed to renew her med. certification before it expired. All med certs have been reviewed and staff are updating any lapsed certifications. A new directive has been issued to all SMR staff stating they will be placed on suspension should their med certs lapse.
- QIS Follow-up:** Thank you for your prompt response. It appears that the policies and procedures of Spring Meadow Resources regarding Medication Certification provide staff ample notice and supports to obtain or renew Medication Certification, and become proficient in SMR medication assistance procedures. The newly developed SMR directive to suspend staff also appears to be a significant deterrent to staff allowing their medication certification to lapse; and if properly monitored, will decrease the possibility of staff whose med certification has expired in assisting consumers with medications. I would like further information, however, on what methods the applicable supervisors of Spring Meadow Resources will use to monitor the training list distributed by the Training Coordinator, Medication Logs, and other relevant information to assure staff who have not previously been med certified, as well as those whose certification has expired, do not assist consumers with medications. This is in light of the fact that one of the staff involved in this incident is the Group Home Manager, who though clearly aware (as was her supervisor) her certification was expired, continued to assist consumers with medications; and permitted staff she supervises to assist consumers with medications despite their lack of proper certification. Please provide this additional information on this Quality Assurance Observation Sheet no later than June 25, 2007.
- FROM SMR:** Training coordinator will indicate medication certification expiration dates (and due dates for new staff) on the monthly training list. Assistant director receives a copy of list and will follow up with disciplinary action when dates are passed. Health Specialist and Residential Services Specialist will do medication sheet spot checks at the group homes.
- QIS Follow-up:** Thank you for the additional information. I am confident that in addition to the new SMR Directive, and implementation process, regarding expired medication certification; having the Health Specialist and Residential Services Specialist periodically check the medication logs will successfully curtail non-med certified staff from assisting consumers with their medications in the

future. Medication logs will continue to be periodically reviewed by the Quality Improvement Specialist during on-site visits. I anticipate there will be no further issues of concern regarding staff assisting consumers with their medications.

Your prompt and thorough response to this incident is appreciated.

STAR Cab Company - Review date 4/29/08 (QIS MK)

Finding: When comparing ride logs with invoices it was discovered that STAR Cab failed to bill for some rides and did not record some rides that were billed for. Ride logs for April-July1, 2008 will be submitted and compared. (QAOS dated 4/23/08)

Correction: Few rides were given in vehicle with no ride log. Rides will be recorded regardless of vehicle use.

Finding: While looking over the van and checking for safety issues it was discovered that there were no emergency supplies or a fire extinguisher available in the backup van. (QAOS dated 4/23/08)

Correction: Didn't realize it was required and have put fire extinguisher and first aid kit in GMC van.

Visage - review date 6/27/08 (QIS LW)

Finding: The agency policy manual appears to be comprehensive and generally mirrors the State policy and ARM with a few very minor suggestions for change. (QAOS dated 6/27/08)

Correction: VISAGE is a newly opened, operating facility. During the duration of our providing services- we have built and adapted our Policy and Procedure manual to fit our agencies guidelines, State and ARM guidelines. During the course of our review some ideas for suggestions were recommended by our QIS. Which we have, of course, reviewed and find agreement with VISAGE has reviewed the suggested recommendations for adaptations to its Policy and Procedure manual. We have made the corrections and changes that were suggested. A copy of the newly changed Policy and Procedure manual is being sent to our QIS for final review. Should there be added recommendations for amendments- VISAGE will complete those in a timely manner and resubmit for final approval.

Finding: CPR is expired for staff. Staff were previously certified so are still trained but do not carry current certification. This needs to be completed ASAP but no later than August 1st. (QAOS dated 6/27/08)

Correction: VISAGE has contacted American Heart Guidelines who is an agency that offers training for CPR- to American Red Cross. They are willing to assist with the training of our agency staff. There are 2 options for training: 1) one to

two staff can receive individual training at a fee of \$80.00 per person 2) VISAGE can hold a class with a larger amount of staff to be trained- which offers this agency a more cost effective method in ensuring all its staff are trained. The fee for the group setting is \$40.00 per person. Since we are in the process of opening a second site on or around September first- where more staff will be hired to fill those shifts, and the first site will also need added staff hired- we are suggesting/requesting that our staff be offered the training as a group with American Heart Guidelines- at the lessor cost. toward the end of August 2008.

VISAGE is also looking into sending one or 2 of its key staff to receive training as an instructor so that this agency can facilitate trainings as the need arises.

Finding: The agency has excellent client surveys but it is suggested that those surveys be expanded to include families. The agency also will need to develop a staff survey before the next review cycle. (QAOS dated 6/27/08)

Correction: As our agency has only recently opened its doors for services- and has had very limited staff assistance (1-2 part time staff) during this review period- this was not something we had initially focused on. As those working with and for the clients are partnered into the agency. We appreciate this suggestion- and hope that our employees or future employees will find the survey implemented to help them throughout their carriers or time with our agency. Attached is a copy of the employee surveys that we will have placed at all locations. They will be required to fill out annually- before VISAGE'S review- and located at the sites so that staff can fill them out and submit them anonymously to further ensure that concerns or comments can be addressed more promptly. To add- it was also suggested that a Family Satisfaction Survey also be completed. VISAGE has implemented this suggestion and also attached a copy for record and review.

West Mont, Inc. - Review date June 4, 2008 (QIS PK) **No significant deficiencies were noted.**

YWCA - Review date March 28, 2008 (QIS SM)

Finding: One data collection for attending doctor's appointments, budgeting, banking, housekeeping, grocery shopping and redeterminations for consumer were filled out in advance of completion for 5/31/07.

Correction: The support specialist will be shown the documentation from the state, asked to respond in writing and will be given a written reprimand for documenting objectives prior to completing them.