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May 16, 2005

To: Jan Cahill, Executive Director
Dick Dittmann, Board Chair

From: Leslie Howe & Lori Wertz, QIS

Re: Summary Report: Quality Assurance On-Site Review FY05

The scope of this review covers Fiscal Year 2005. The annual on-site review portion of the quality assurance process was conducted during the period of December 1, 2004 through April 8th, 2005 for anticipation of a final report in April 2005. References and guidelines are found in the DDP handbook titled "Quality Assurance Process for Adult and Group Home Services" dated July 11, 2003.

This report contains findings, comments and recommendations noted during the reviews of the agency properties, supported living and community support programs in Great Falls, Conrad, Shelby and Cut Bank. It also includes observations from scheduled/unscheduled visits conducted over the past year and a desk review of trend analyses.

The format of this report will look somewhat different than that of the previous year. While individual sites were visited, the information was compiled to reflect agency/administrative directions and pull the sum of the available information back under the umbrella of the agency as a whole. Quality Assurance Observation Sheets are attached for both exemplary practices and for deficiencies as found during the review. Exemplary practices do not require reply, however any deficiencies or recommendations noted in this summary will require response by the date noted on the Observation Sheet.

Please note, the State evaluation process is by no means as detailed or specific as the internal QA monitoring system for this agency or the ongoing licensing reviews completed by other agencies. We made every attempt to incorporate the findings from licensing and county health in this review but understand that our findings may or may not reflect similar findings in internal or related processes. Through email correspondence, phone calls and self reporting by QLC staff, it is apparent that the agency's internal QA process is quite thorough and recognizes issues before we as the funding source see them. For reasons that are unclear to us however, follow-up and coordination of preventative strategies based on the internal QA process appear to be limited. One noted concern in this evaluation cycle is what appears to be a lack of solidarity of purpose for the agency. Instead of correcting issues with the intention of preventing recurrence, agency response has consistently invested effort in discrediting or blaming other agencies or entities for whatever issue is at hand. Documentation shows Management responses which attempt to shift blame to APS, Case Management, DDP, the CEO and even to individual staff persons–without apparently considering the responsibility that QLC might have as an entity in the overall process. Checks and balances appear to be limited or lacking generally. That individual consumers are well-served is a credit to highly devoted individual staff persons, more so than any agency related impetus.

I. GENERAL

Administrative:

Quality Life Concepts provides an array of services to approximately 144 adult consumers, covering Cascade, Toole, Pondera and Glacier counties. Residential services range from community supports, to group home (standard, intensive and senior) to supported living and report directly to the CSP Director. The residential and vocational components of the agency were split this year with the addition of a Vocational Services Director. Work services, supported work and work activity programs report to this position, as does Quality Assurance internal to the agency. Both the residential and

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vocational directors (as well as the HR Director, HBS Director and Fiscal Director) report directly to the CEO. The split of services certainly makes sense particularly when considering the size of the program overall, however, it also seems to have caused some communication issues as well. In the past, the CEO has acted as the liason to the DD contract so that communications pertaining to agency-wide practices were disseminated through a single point of access. With the changes in agency structure, it seems that more of the daily operations fall to the Directors (or maybe more specifically, the Management Team). This has created some communications gaps–Directors report they have no knowledge of information shared with the CEO from this office, and when trying to resolve contract or consumer issues, information does not appear to be shared equally among or between the Directors. This has resulted in some issues of accountability–either with someone thinking someone else completed follow-up, information being left unidentified or in transferring the responsibility to another department. This trend is supported in various emails, incident report follow-up and maybe more tellingly, in agency QA memos. There have been regular occurrences throughout this year when agency identified trends went uncorrected, causing involvement from this office when the issues may have been resolved internally. Some of these examples include: the inappropriate rights restriction on . regarding phone use, numerous emails regarding cleanliness of group homes (some of which were eventually corroborated through health inspections–South Park being a prime example).

The agency also added a fund-raising position this year. It is apparent from the increase in advertising that the addition of this position is creating a much needed higher public profile for the agency. It is noted that the current website, and radio advertisements do not carry the prerequisite disclaimer regarding State funding (attached). A recent newsletter suggests that QLC will also have a State license plate available this year that may help increase revenue through the Sponsored Plate Program.

The closure of the Shelby program site (with that home turned into office space for the CFS division), spurred the opening of a second group home in Conrad and an increased number of persons served in the Conrad work activity. Additionally, several long time group homes were closed in Great Falls and replaced with newer homes. While the upgrades of some of these homes may have been necessary, not all of the consumers benefitted as much as may have been expected. For example the eight ladies at the Riverview site have much smaller space than their previous home. While the home itself is very attractive, there is limited closet space, many egress points and inopportune steps to negotiate. The size of the bedrooms, concerns about room sharing, and a furnace in the closet brought a litany of complaints from families and Case Managers. This in part prompted the addition of the garage bedroom. Egress to the newly added bedroom traverses through an existing bedroom shared by two ladies. The home was reported to be rather expensive, and required additional dollars to bring it to licensing standards. In the meantime, the Park Garden group home site became home to the men from Hansen house with the former site becoming a respite home. The folks from Horizon house just hosted their open house at their new Laurel group home location and this will be a much better, accessible location for them. Horizon is slated for sale. Throughout the shuffling of group homes, the agency expanded by 6 group home consumers (5 MDC folks in October 2004 and one supported living person amended to group home). The proposal for the MDC expansion requires the agency to have a nurse on staff at that home, a definite benefit to the consumers served there. It is noted that when the Shelby work site was closed, the agency promised to continue to serve all consumers from that area. Unfortunately, one consumer did not receive services for several months due to agency/fiscally related transportation issues. At one point during this time period, one part of the agency was calling to complain that they weren't maximizing the units on this contract, while another part of the agency was being told it was too expensive to drive to Cut Bank for just one consumer. It was not until a screening held in March 05 that the agency deemed it viable to transport this individual with a new consumer from Shelby so that service could be resumed.

Throughout the movement of individuals between sites, information relayed to IP teams, DDP and Case Managers changed frequently and without warning. Complaints were registered by Case Managers, IP Teams, Guardians and parents that they were not involved in the process or even consulted. When IP teams were involved, decisions were made based on information from the agency outlining 'consumer need,'only to have those plans and subsequent to that, the "needs" of those individuals change completely. In some situations, IP teams were told there were no other options for the consumer, creating less than ideal situations for the individual and eventually prompting further moves and disruptions. Concerns were sited that some of the moves were strictly for agency convenience, based on the 'next best idea' as opposed to any well thought-out, thoroughly researched plan which truly took into account individual need. This was further evidenced by the fact that in the final analysis, one consumer in Great Falls was left with no physical place to live. While this individual would certainly have retained his services, it left several uncomfortable weeks in which options were considered to further disrupt others in order to accommodate the error. As a result of this oversight, one group home was temporarily increased to a licensure of 9. Eventually, the dilemma was solved through attrition and the movement of one vacancy to Conrad. This rectification was happenstance....a port opening created an unexpected bed.

There have been three consumer deaths at the agency this year. One due to age and heart related issues, one hospitalized initially for bowel obstruction, and one due to a choking incident at the group home.

Finding appropriate staff ratios for Appendix I have been an ongoing concern since last review. In some cases, consumers were added to Group homes but staff were not. Additionally, QLC has mixed and matched intensive and standard folks, creating concerns for minimum safety of consumers in those sites. The Regional Manager at the time of the MDC expansion put his concerns in writing to the Developmental Disabilities Program in September of 2004. He specifically stated movement of individuals to various homes, mixing intensive and non-intensive folks and the agency's inability to meet staffing ratios were concerns.

By staff report, ratios are being met by committed staff working very long hours (sometimes 18 hour shifts), coming in on scheduled days off (see staff ratios) and working across group homes and service areas. While some staff likely appreciate the over time checks, the rate for burnout and the potential for inadvertent consumer health and safety issues is a clear risk that was previously identified by CMS at the Shelby group home site (Shelby corrective action, 2002). The agency has recruitment incentives in place and does a good job of trying to attract employees. The agency is noted to pay from .20-.50 per hour less than other providers in the area–although it is noted that some providers in this Region pay a slightly higher dollar rate but offer no retirement or benefits. Past administrative decisions have contributed to the current rate: monies from the State were put into administrative efforts (worker's comp, benefits, etc...) as opposed to an hourly rate. Additionally, other providers elected to capitalize on expansion (movement of MDC folks with higher cost plans to the community) more frequently. DDP understands the difficulty in hiring and retaining qualified staff, but we also hear clearly from staff that many other issues attribute to their decisions to stay or leave. Frustration and accountability are commonly heard themes. Over the last year, RSS level staff have been transferred from program to program (Community Supports, Supported Living, various group homes) such that no one person has enough history to develop meaningful individual plans or provide any significant amount of accountability or responsibility for the program or individuals served (this was addressed as a concern in the last eval as well). Additionally, those same staff are frustrated when at some point they have come full circle back to their originating programs, only to find all of their hard work and energy for naught when they have to effectively start over with staff training, documentation, programing and the like. Staff training for the RSS level of management appears to be non-existent beyond what those individual staff can glean from veteran counterparts. Although the RSS position carries additional responsibilities, the training that is available appears to be more geared to agency forms (payroll, for example) and not consumer services. In fact, there are few RSS level staff left in the agency that can write measurable objectives or goals, reinforcement schedules/programs or that have a working knowledge of client rights policies, individual planning or reporting policies. This becomes a much bigger issue when one considers that direct care and Resource Coordinator level staff (where turnover rates are greatest) rely on the RSS position for guidance and on-the-job training for issues that come up outside of the generally covered curricula. When staff misstep, they are often moved to another area or home–where they may continue to make the same errors in the new environment–often not apparently understanding why they were moved or maybe without requisite training to effect positive outcomes. Some staff have stated concerns that although they have willingly worked longer hours or come in on scheduled off time, that when they need an accommodation to get to the bank, or run a personal errand, they are unable to do so–that in fact, they feel as though they are 'required' to accommodate the agency but remedial support to them is lacking. Direct care staff have stated that they feel they are nothing more than babysitters, that they would like to have part in the planning process and be able to implement their ideas more freely. In some cases, they have stated that 'management' appears to make decisions without consulting the staff who will be implementing them. Additionally, staff at various levels of the agency report that there is an 'inner circle'–people that appear to be favored or treated differently than those outside of that group. Whether or not this is true is not as much an issue as the fact that such perceptions in an agency tend to polarize staff, create mistrust and prevent effective teamwork–and ultimately impact staff turnover.

A review of available agency policies shows that some policies do not mirror Administrative Rule (reporting policy, power of attorney, individual planning, etc...). We are waiting for an updated policy manual to determine whether this continues to be the case.

Accreditation:
QLC carries a three-year accreditation under CARF with most recent review having been completed in August 2004. The CARF report notes numerous strengths for the agency, including its active board, new CEO, active recruitment efforts, excellent transportation program, and record keeping to name just a few. Several recommendations made by CARF have been incorporated into the body of this report where we found similar considerations.

Licensing:
Licensing reviews were completed in December 04, as well as Fire Marshall inspections. County Health reports for this time period reflected concerns that were mirrored as part of this review. These include: water temps at higher than 120 degrees (South Park, Senior Day), unlocked cabinets with cleaning supplies (Meadowlark, Park Garden, Riverview, Shelby WAC while it was open, Skyview, South Park), lack of supplies in bathrooms (Park Garden, Riverview, Skyview, Western Star, Willow, South Park). It is noted that the deficits in the County report were rectified prior to the State licensing agent visits which may account for the differences in those two reports. However, the County report also

mirrors issues noted throughout various site visits by Case Managers, DDP staff and through agency self reporting this last year. This suggests that the issues are ongoing but that staff may be more vigilant about rectifying them around licensing times.

Fiscal:
Annual audits for June 2003 were on file, completed by Junkermierer, Clark, Campanella and Stevens and disclose no significant findings. Reports note that QLC has "complied in all material aspects...." and show "no material weaknesses." An HHS Audit Bureau desk review of QLC by Jean Paris (August 04) again makes notation of 'no findings' and states that QLC is considered a 'low risk auditee.' The Regional Manager indicates no outstanding/overdue financial reports at this time.

As quoted from the FY 04 Comprehensive Eval:

> *"It is noted that the 2001 CARF report recommended some revision ("tighter control") in reference to individual consumer accounts and it is similarly noted that questions involving consumer funds have arisen episodically through the last review period. Specifically, questions arose with reference to monies lent to consumers outside of IP team involvement (the consumer misunderstanding the terms) or questions related to staff purchasing items or services from consumers (consumers assisting staff or other consumers in moving, staff buying from or selling furniture to consumers, purchases of fund-raising event tickets, or items that staff would sell such as AVON, tupperware, or other craft or related items). The agency has always responded quickly and appropriately to such questions as they are asked. Since the concern was noted both by various Case Managers and by CARF, it is however suggested that QLC consider the development of some 'best practices' policy that would give the staff guidelines for such circumstances that would help protect both staff and consumers from allegations of inappropriateness."*

This previous recommendation, as well as concerns from Case Managers, Guardians and staff, prompted a more in-depth look at individual consumer spending this year. Although receipts and expenditures were reviewed for one home in particular, the findings are considered to be reflective of agency-wide policy, based on interviews with Managers in other homes regarding the types and amounts of expenditures in their sites. Areas of concern are as follows:

1) Consumers are being charged for items which would typically fall under the Medicaid definition of 'room and board'. Such expenditures include: sheets, blankets, mattress and pillow covers, food items, bedroom furnishings. Medicaid allows for the use of personal needs money for outings and recreational events (trips to McDonalds, ordering Pizza on football night, etc...understanding that the staff's share must be covered by the agency, not the consumer). However, purchases of dinner items (pumpkin pie and whipped cream for example at Thanksgiving) are considered covered under agency room and board. Likewise, any item that is generally provided in a hotel is considered an R&B expense. Consumers who need to 'spend down' in order to retain Medicaid eligibility may elect to purchase some personal items of this nature. However, when the agency is payee and elects to make those purchases on the consumers behalf, the purchase becomes a question of whether it benefits the agency or the consumer. A vacation for example, has no apparent benefit to the agency but would mean quite a lot to an individual consumer. Furnishing a bedroom, while aesthetically appealing to the consumer, has direct benefit to the agency by reducing the overall cost of maintenance and upkeep. This issue has been raised several times over the last three years to agency staff and apparently still is unresolved (charging consumers for paint, additional phone jacks, etc...)
2) Consumers are being charged for items common to the household. Such items include: home decorations, home furnishings (entertainment centers, laundry soap, curtains, furniture, dvd players, Tribune delivery, etc...) This too has been raised as an issue several times over the last three years. In this case, the explanation has again been offered that a consumer needed to 'spend down' and 'choose' to purchase the items for his house mates. Because the consumer would not likely 'choose' such an option unless it was presented, AND because the agency acts as payee, this again raises the question of propriety. If the individual's items are destroyed due to the actions of another individual in the home (eg: the TV is tipped over during a behavioral altercation, or the couch is ruined due to incontinence) there is no reimbursement to the individual (the consumer who causes the damage cannot be charged). Likewise if the individual moves to another service provider, he or she is entitled to take all of their possessionss with them–potentially leaving the home without key furnishings. Similarly, if the individual 'owns' the common TV, that person can renege on his generosity–unless of course the person doesn't realize he/she has that power–which raises the issue again of whether undue influence perpetuated the purchase in the first place.

3) Staff are being reimbursed to shop on behalf of consumers, without consumer input and in dollars that appear to be in access of item value. In one case, the staff person was reimbursed nearly $700 for used furniture and items purchased in Billings. Payees are appointed to individuals because the individual lacks the ability to manage his/her finances–either for lack of skill or for their vulnerability and suggestibility. For these reasons it is tantamount that a representative payee be above reproach in terms of any appearance of impropriety, undue influence or exploitation. It is understood that the agency has a policy in which purchases over $500 be approved by either the CEO or TWO members of management team. However, in the case just cited, one member of the management team was in fact the staff person being reimbursed, which again raises a question of propriety.

4) Items are being purchased by consumers (or in some cases by the agency) from other consumers or agency staff without an apparent means of discerning fair market value. Similarly, there have been numerous complaints that staff hosted parties (Tupperware/Avon/candle or craft) parties that have consumers as guests, creating a 'captured' audience. Fundraising tickets have apparently been purchased by consumers through their contacts with staff persons related to those events as well. These findings seems to corroborate the 2004 CARF recommendation: *"The organization has an ethics policy for employees, and each member of the board of directors signs a copy of the code of ethics. Although these documents address important ethical considerations, it is recommended that they be revised to address each of the components of the standards. In addition, the organization is urged to develop written procedures to deal with alleged violations of the code of ethics and related policies to educate personnel and other stake holders regarding the code of ethics"* As noted at the beginning of this section, this issue was raised in the last comp eval, with a copy of best practices specifically recommended and attached to that report. It is unclear whether the agency acted on these concerns.

5) Cable purchases are being prorated at the agency's discretion from a bundled and highly discounted package from Bresnan that includes not only the cable, but high speed internet–a service not used by the consumers but generally considered a operating expense for the agency. The prorated expense approximates one-half of the overall expense, while the high speed internet is generally considered to be three times the cost of cable. While the prorated cable cost may be appropriate, it is not clear whether the consumers are benefitting from the discounted agency package, or whether the agency is benefitting through a consumer-subsidized internet plan.

6) Complaints have been noted with regard to monitoring funds for supported living consumers. One consumer ported services to another provider over complaints of money/spending. Another consumer has managed to go through all of his money in a span of about 5-6 months, including savings. QLC has recently threatened to stop acting as payee for a consumer because they can't get financial information in order with her even though she has always been uncooperative to some degree. Concerns about monitoring consumer finances in the SL program are not new. Instances of paychecks not reported to Social Security, loss of HUD benefits for failure to follow appropriate notification, failure to balance consumer check books and even failure to address rental increases are a few examples of past concerns.

File reviews also showed that agency staff retain power of attorney for some individuals. Please see the attached clarification from HHS legal outlining why this practice is not recommended.

Transportation logs are being maintained at all sites on a per individual, per ride instance. In fact, the transportation training and record keeping system is very thorough and well developed.

QLC utilizes an on-call system, the efficacy of which is determined by the individual responsible at any given time. Just recently the on-call staff made a report to the Developmental Disabilities office concerning a consumer who went to the emergency room for treatment. The on-call staff was unaware whether the consumer had a Guardian. As has been identified in Observation Sheets this year, notification of appropriate parties (Guardian, Case Manager, DDP, advocate) has not been consistent and in some cases was non-existent. With the new Incident Management Policy in place as of 4/15/05 (to be fully implemented by no later than July 1, 2005), this will become more important. While the agency uses some type of 'on call book' which is supposed to outline basic information regarding consumers, it is not clear how useful or readily accessible that information truly is. There have been complaints from consumers that when they try to access the on call number, they either get no response, or the staff is unable to help them. It could be that the on call system which would have originally been developed to deal with emergency situations (and presumably most emergency situations would follow the same kinds of agency policy) has grown beyond what is reasonable to expect of any staff. If the agency finds that the on call system is being used for issues other than emergencies, a restructure of the system may

be beneficial. There is a perception that all of the responsibility for decisions falls to the RSS and higher authorities–when in fact, empowering and trusting staff at all levels of the agency may be more efficient in the long run. For example, a supported living consumer running short of spending money may be indicative of poor advance planning, and not an emergency. If the consumer and his/her direct care staff have to take the responsibility to plan ahead, that is one less 'crisis' for the on-call staff to have to remedy.

Staffing/Screening/Hiring:
Five staff files were sampled for this section of review. The files clearly documented orientation training, MANDT, CPR, First Aid, OSHA, QLC policy (client rights, confidentiality, abuse/neglect/exploitation, incident reporting, etc...), and Abuse Prevention. It is questionable whether training is having the desired effect. In times of stress, staff have reverted to non-MANDT interactions with upset consumers, and in another case, an supported living consumer was hired as staff to a group home. In the latter case, although the consumer/staff was credited with completing the trainings, it was noted that he was allowed to take the final tests home to complete them, begging the question as to whether *he* actually did them. It is not clear that all staff working in intensive homes are enrolled in the DDCPT or in this case Level I training (approved equivalent) according to the contract. In one file, (PRH) didn't have the training listed, but it could be that it was an issue of updating information and not lack of training. The lack of enrollment for intensive staff was cited in the last review as well, and although the agency reports that all staff have access to Level I training, staff themselves report having 'great training programs, if you can get to them.' Induction is being lengthened from three, to five, to 8 days and now includes an onsite shift that is not counted for the purpose of staff ratios under Appendix I. It is noted that this orientation program (August 2004 revision) has not yet been approved by the State according to contract. Staff surveys indicate a potential concern with effectiveness of the current training in that staff consistently missed answers to questions related to incident reporting and reporting to agencies outside of QLC (Case Management, DDP, Adult Protective Services, etc..). Many staff members required prompting as to when an incident report was needed. Most staff were unable to answer the question about to whom reports should be made–in fact, the answers clearly indicated that staff knew the chain of command internal to the agency but had little knowledge of inter-agency requirements. One staff could not identify "APS" although he was hired to a management position. In another case, a staff answered every question incorrectly, even with prompts. Additionally, new staff (employed less than two years) were unable to answer questions related to individual planning without generous prompting. Even at that, responses were vague and indicated that direct care staff have little input into the IP process and do not appear to recognize that process as central to consumer's lives.

The agency no longer uses an extensive relief staff list. Instead, staff are hired as permanent full time to a specific home. This allows the staff to access benefit packages that would not be offered at the relief level. If after 90 days, staff do not pass the med test, they are demoted.

Criminal background checks are completed on all new staff prior to their employment. Documentation is current for the staff sampled. The agency has noted that APS background checks have not been helpful in that specific information is not shared with the agency, making it difficult to determine employability. As is the practice with this agency, if a background check creates questions, the employee has the ability to provide a written statement of the situation. That documentation is then reviewed and a determination is made whether to hire. There was an issue this last year wherein a staff person is alleged to have driven a consumer at high speeds in an agency vehicle. The staff person was within the probationary period and was terminated. From our perspective, the agency was in compliance with their contracting guidelines and did take appropriate action. Concerns from APS centered on information obtained from alternate sources that may have created questions at the time of hire had the agency been aware of the information. While we agree that the findings with APS have merit, we also believe that the agency has adequate safeguards in place to the extent they are able to obtain information. In the absence of staff certification or legislated criterion under which people might be excluded from working with vulnerable others (similar to what the CNA program uses now), the agency must continue to make hiring decisions based on current DOL standards. Once persons are employed however, the manner in which the agency supervises, evaluates and retains staff becomes a critical issue. Consistent application of agency policy and procedure becomes pivotal, and decisions to retain or dismiss staff need to be balanced against consumer safety and agency liability. To that end, the agency appears to be tightening its policy and procedure. In the past, questions have been asked as to why certain staff are retained amid complaints of inappropriate consumer interactions, allegations of theft (from the agency or from consumers) and a multitude of other issues.

As previously noted, observation sheets included concerns regarding incident reporting and incident management within the agency this year. Although the agency has multiple levels of review for any incident, it is unclear what checks and balances exist and with whom the responsibility lies in terms of follow-up and recommendations. To site specific examples; the DD office received an IR on a consumer stating that staff attempted to restrain him with a 'half-nelson'(10/26/2004). This is not an approved MANDT technique and is considered very dangerous and inappropriate, yet the incident report was signed off by the Group Home Manager, and the Residential Director, with no notation of intervention, training or concerns about the 'restraint.' The internal agency QA documented concerns on 11/3/04 and sent

multiple emails to CSP staff.. DDP didn't receive the IR until 11/24 (nearly one month after the fact) and generated an observation sheet. At that point, the Residential Director interviewed the staff (date 12/2) and determined that it was not a half-nelson hold, that there were no health and safety concerns and that because the State was developing a new IR management policy, there was confusion about what was expected from providers in terms of response. In point of fact, whether under the 'new' policy or the ARM, an incident described such as this one would ALWAYS have resulted in agency response to safeguard the consumer and provide additional training to the staff.. That this was identified by the internal agency QA is a credit, but that veteran staff did not recognize the issue, and that follow-up did not occur until the DDP office got involved is a concern. This does not appear to be a 'situational' example: several months later, a consumer was injured in his home and required medical treatment. Notification timelines were again not met, however, the incident report was again signed off by the Residential Support Specialist and initialed by the Residential Director–without noting that the consumer waited several hours before getting medical attention, that the on call system was apparently not utilized according to internal policy. The injury (noticed at 6:30am) may well have occurred during the night shift (subsequent reports indicate possibly as early as 4:30am). In neither of these situations was APS notified by the agency. Even if one considers the extreme nature of these cases, it is hard to understand why agency response to such seemingly obvious consumer safety issues wasn't more immediate or didn't follow reporting guidelines. The question is also asked if the obvious issues are getting missed, what level of scrutiny are the less serious issues receiving? On the heels of these concerns, agency staff have noted that the number of incident reports is generally decreased and that they believe they have a general failure to report due to staff reluctance to use the new reporting form. This was also documented via email with respect to (Central Park), requesting immediate follow-up by the RSS for staff not reporting 'behavioral' issues in that home. It is unclear whether the new Incident Management Policy will resolve some of the agency related reporting and follow-up issues unless the agency also clearly designates authority and accountability for follow-up to an appropriate administrative level.

Interagency relationships seem to be strained. In May 2004, a meeting was held at the request of APS concerning what that agency perceived as a lack of cooperation in reporting and investigation. Additionally, in January of 2005, letters were received from Dr Harkness stating that he would no longer treat consumers with the agency (specifically Phoenix group home). In follow-up to that concern, it was noted that the doctor felt that he was being unfairly accused of neglect by staff persons. The only documentation provided to the allegations were by staff via medical reports and did not appear to be substantiated in the doctors records. As previously noted, there has been some concern that issues are blamed on other agencies (APS, Case Management, DD) as documented in QLC quarterly progress reports and various correspondence.

There seems to be a preoccupation and concern for funding that exceeds the concerns brought about by changes in the system and rate setting guidelines. It is not clear, although the agency has said they are solvent, that fiduciary issues don't exist in tandem to the system changes. Whether this is in part due to the purchase of new homes and agency expansion, the costs of over time in relation to staffing existing sites or some other issues are questions that have been raised. Staff have stated that the group homes cannot purchase vacuums or necessary cleaning supplies due to budget restrictions. In other instances, administrative staff have requested exit of consumers in temporary nursing home placements in order to maximize dollars in the contract when in fact the agency was allowed and continued to bill for those persons while they were convalescing. Recently, the agency has asserted that it will no longer provide transportation or other related services to individuals for whom this service has always been included. It is noted that the agency has sometimes provided services to groups of individuals (Central Park supported living) so that individuals can share staff resources. When agency-driven decisions are made that effect consumer services (for example, turning Central Park into a group home), the needs of those individuals still must be met.

Adult Protective Services:
APS has been involved with agency investigations for more than 40 consumers since the last review. While the number of reports is not indicative of quality of services, it seems important to note the kinds of referrals made. Allegations this year included: staff to consumer abuse (mistreatment of consumers, suspected verbal or physical abuse), failure to respond with prompt medical/dental treatment or care and unexplained injuries. There are numerous investigative summaries still open. Under the new Incident Management Policy, the agency will have a mechanism to more formerly track these investigations, as well as work out a procedure with APS to determine protocol for how investigations are conducted (who takes the lead, who is the contact, etc...).

II. SPECIFIC SERVICES REVIEWED

GROUP HOMES:
As previously mentioned, QLC has upgraded their homes through the purchase of several new sites. Throughout this process, the agency effectively gained six consumers with the same net number of sites served. Several group homes across the service area *increased* their occupancies, creating more consumers per home. One group home decreased from eight persons to seven. The 04 CARF recommendation J.1.a and subsequent consultation encourage the agency *to reduce home sizes* of six or more and to provide individual (vs shared) rooms. Even with the purchases of new homes,

room sharing continues to be a consideration. Some homes that were serving three or four individuals are now serving four, five or six persons.

The agency was successful in finding a dentist willing to accept Medicaid payment this past year.

Observations and corrections from the **previous review** generally include the following:

A) General cleanliness and repair of homes; some repairs were incorporated but the two houses in most need were replaced (Hansen and Horizon). Hansen is being refurbished as a respite home, and Horizon is being sold. Park Garden group home is noted to have ongoing water damage issues, determined likely from upstairs bath. Water alarms were installed based on these findings in the last eval. Willow repairs were completed.

B) Lack of IP documentation, use of checklists, general documentation regarding recreation, leisure, fire drills, medical appointments, quarterly reports, etc...; checklists are somewhat less prevalent, Residential Director to review all IP packets prior to IP, attempted to develop an IP task force to address ongoing IP and related issues. Lack of fire drill documentation seems to have been resolved by having QA staff monitoring the drills (documentation may not always be at gh sites, but is available at the main office).

C) Consumer interaction concerns–potential issues with control of consumer (then at Primrose), concerns regarding alleged abuse, neglect or exploitation of consumers at Horizon; moved to Central Park GH, staff turnover at Horizon House (now Laurel) reduced but not eliminated the unexplained bruises, breaks and other injuries of consumers in that home.

D) Lack of timely implementation of IP objectives, lack of medication objectives or documentation that an objective was not needed, long range goals lacking or unrelated to objectives, objectives not meaningful or not related to assessed needs or wants, rights restrictions that were unnecessary or unclear: despite training in the agency, these remain a concern.

E) Staff ratios not in compliance with Appendix I; agency offered training on expectations. This remains a concern.

F) Cleaning supplies not locked up according to policy, bathrooms not appropriately stocked with toilet paper, soap and paper towels; addressed through an agency checklist, remains a concern.

G) Recreational and leisure activities not meaningful or documented. Agency responded with internal training and a change in internal forms that would prompt staff to not include administrative duties (filling vans with gasoline, medical appointments, etc...) This remains a finding for the 05 evaluation as well.

H) PRN protocols were not consistently on file across sites. Agency response included use of CM checklist at IPs. While most protocols were found in the 05 review, it is noted that many protocols, especially for motility drugs, do not include clear criterion for when a) the drug is to be administered or b) when medical treatment is warranted. This remains a concern.

I) Hot water temps that exceeded 120–agency responded by turning water heaters down, however, it is noted that some sites were out of compliance again over the course of this year. This finding is also confirmed in sanitation reports.

J) Staff surveys: staff appeared unsure as to how to respond if a supervisor or authority wasn't present. Agency responded that it would use some of the staff responses as training tools. Staff survey responses remain a concern in the 05 eval.

K) Community supports plans did not contain objectives related to the expenditures of funds. Agency response included that Case Managers should be aware and ask for this. This remains a concern in the 05 evaluation.

Observations and agency responses for the **current year** include:

A) Consumer interactions: concerns regarding inappropriate staff to consumer interactions, specifically consumer at Central Park, \ at Ramuir, from Treasure. Agency responded with either

internal investigation and/or additional training of staff. Concerns remain about sign off procedures (incident reports were signed off at multiple levels of the agency but identified as client rights issues).

B) Medical Care: consumer noted to have 'gross periodontal disease related to severe neglect' as noted in the dental report. Agency identified falsification of documentation in this home. Another consumer in the agency had emergency surgery the result of such poor dental care that caused abscesses and illness. Multiple hospitalizations for bowel issues, constipation and obstructions. APS has been involved. Agency has developed a bowel chart policy but it is not found in all homes as of this writing. PRN protocols as previously mentioned, do not contain clear criterion of when motility drugs should be given or when medical follow-up is necessary. Agency has found a dentist who will accept Medicaidand is attempting to rectify dental issues. Dental reports citing 'good' dental hygiene (consumers assisted by staff) are still the exception rather than the rule. Timeliness of medical treatment, use of the on call system and appropriate consumer intervention caused an apparent delay of over four hours for an individual in need of stitches at Ramuir Villa. That investigative report is still outstanding although the incident occurred March 19, 2005.

C) Reporting time lines are not being met in terms of alerting appropriate other agencies, Guardians, etc.... of emergent care. Despite the fact that the new IR Management Rule has been in the works for more than a year, the agency has not yet developed its internal management system to address that policy. The agency has until July 1 to fully implement the policy. Additionally, staff responses to surveyed questions indicate a propensity to report internally but not alert appropriate other agencies. Please see the concerns cited earlier regarding the on call system. DDP completed training at an all staff meeting on April 20 at the agency's request.

D) Medication Errors: while the agency maintains it has a 1% rate of error across all services, we have concerns about the number of medication errors (documentation errors, wrong med/wrong person, meds not given, wrong dosages) in some sites. Outdated medications were found in several group homes. Concerns with PRN protocols are ongoing as previously mentioned. As an example, a PRN for Ativan for seizures had no accompanying protocol. In another instance, non certified staff passed medications–a second offense for that particular home. In yet another case, consumers were not given meds because there was no med certified staff on duty and staff did not call on call as directed by agency policy. The agency appears to have adequate training curricula and policies in place, but is unclear whether there is a 'practical' application to the process (eg: whether the training translates to actual practical experience for staff). In the transition of MDC folks to Primrose, Senna Paste was listed on the medication sheets, but not given for more a month. When asked, the Group Home Manager did not consider this a med error as it wasn't 'prescribed' despite the fact that the IP teams agreed to include/continue it. Internal QA to the agency also identified this as a med error, however no action was immediately taken by the responsible staff. It is not clear that QLC has a detailed process on how medical issues are tracked and addressed. Nor is it clear as to whom is responsible to ensure appropriate follow-up.

E) Staffing ratios: as previously mentioned, Appendix I and staffing ratios continue to be a concern in the agency. In one instance, adult protective services was called regarding the lack of staff at the South Park group home. In one home where the ratio was not met, staff from another home showed up with a consumer–and announced that he was there to fix their ratio. Upon further investigation, the sending group home said that particular staff and consumer were on an 'outing'. While certainly creative, this did not solve the receiving group home's ratio shortage. In Conrad, staff shortages have been significant. Borrowing staff from supported living caused the consumers in that program to miss valuable service hours.

Agency staff are very frustrated by the Observation Sheets. In an attempt to limit perceived issues of potential litigation, the agency responses have included reams of paper and policy but have often circumvented the concerns noted on the observation sheets.

Health and Safety:
As mentioned in the administrative portion of this summary, numerous changes occurred across many group homes this last year. Some homes have seen marked improvement in health and safety, others have raised concerns. Horizon (now Laurel) group home has seen improvement across the board this year. As the reader may recall, this home at review last year was missing data, medical documentation, and individual plans. Additionally, the home was in disrepair and had issues of general cleanliness. While this was noted in the 04 eval, agency response to the findings was vague and related back to the need to change from a focus on checklists, but did not really address the concerns noted. Eventually, issues

were identified and addressed by the agency involving the falsification of medical documents. Since the current Group Home Manager has taken over, there have been good strides in consumer care: medical appointments and emergent care appear to be immediate, with appropriate follow-up. Incidences of suspected abuse and neglect have been reduced and are noted to include more self reports of concerns (vs another agency or entity initiating reports). Even prior to the move to the Laurel location, the issues of cleanliness and repair were virtually eliminated. The group of consumers in this home have been traditionally very hard to serve due to tremendous skill and communication deficits. It is very difficult for staff to see the folks here as adults, and it is easy to slip into parenting/controlling kinds of roles (control food, access, bedtimes, etc). Additionally, two long awaited moves occurred to the benefit of the consumers involved. had money moved from supported living to a group home setting to address her health and safety needs. moved from the Park Garden to the Meadowlark group home. Although the move was precipitated by voluminous complaints by family members on behalf of other residents, it is clear that 's much happier than she has been in years and that the staff in her new setting like and appreciate her for who she is.

Vehicles:
Agency transportation training as previously mentioned is exemplary and is noted in the 04 CARF summary as a strength for the agency. In the course of this review, there were no noted issues of vehicles being out of compliance or in any way unsafe.

Consumer/Medication Safety (psychotropics, training, programs, prns, certification,errors):
PRN protocols are an ongoing issue at QLC. Most PRN medications are in place but not all. Med errors continue as does training to try to prevent them. In the sampled files, consumers who have not reached their maximum independence are on training programs for self-medication. Others have IP documentation that notes no further training is necessary. See the above notation on observation sheets regarding ongoing concerns and medication errors as well as consumer safety issues regarding prompt medical treatment. Consumer safety seems to have much to do with individual staff skills and the level of supervision afforded by either the RSS or RC in specific sites. Specific staff seem to be very conscientious of medical and safety issues.

Sites (appearance, evacuation drills, SL apartments, emergency back-up, etc.):
Not all sites have documentation of drills on site but the paperwork can be found at the QLC office. Agency QA staff will complete emergency drills if they haven't received a response from the homes by a specified date based on a policy developed at last review. This seems to have resolved some of the concerns cited last year with regard to this activity. Drills are noted to be scheduled at various times of day/night and shift as required by policy. The agency did purchase new fire extinguishers for the sites this year. The current CARF report notes a recommendation that the agency develop an evacuation plan for each site (E.4.d- E.4.h). These appeared to be available in some sites but not all. The CARF report further recommends an agency self evaluation at least twice per year at all facilities and administrative sites (E.2.A). The agency is currently using a program called "Assessing Evacuation Difficulty" which allows QLC to assess and address potential evacuation issues prior to an actual emergency.

Cleaning supplies were found unlocked in several sites again this year (including but not limited to Skyview, Meadowlark, Central Park). In at least one home, the games and leisure supplies were locked up, but the bleach and cleaning items were not. In several homes, toilet paper, soap and paper towels were not readily available in the bathrooms (Laurel, Willow, Skyview, South Park, Riverview, CWAC).

Water temperatures exceeded 120 degrees at the SDP kitchen, South Park (knob was actually broken off water heater). One home had the shower knobs mis-marked for hot and cold (Treasure). These findings generally mirror sanitation reports.

All sites with the exception of Primrose have MSDS books on site which outline how to handle hazardous materials, poison control, etc.. There were no noted issues of egress in the sites visited. Smoke alarms and fire extinguishers were in working order, with notation that Berkner group home had a problem with the strobes not being connected. This issue was identified and corrected by agency QA.

Service Planning and Delivery:
Copies of individual plans were generally available at each site, with a notation that in some cases, the plan appeared to be 'filed' without really being scrutinized. As an example, one case had a supported living consumer's checklist and information filed in the group home with another consumer's plan. Although this may be simple clerical error, other portions of the onsite evaluation raise questions regarding the effectiveness of the planning process and whether individual needs are being identified. Direct care staff appear isolated from the process as indicated by survey responses. Checklists continue to be the preferred method of data collection and there is limited training toward independence across all environments. Many 'support' objectives can be met with just one data point in the year (one camping trip, get a fishing license, etc...). There are no written aversive programs in place, although there have been a few occasions

wherein IP teams were inappropriately asked to restrict individual rights. In the absence of an approved program plan, limiting a person's access to their money, attempting to use a person's money to reinforce him or her, limiting access to personal property (cigarettes, telephones) are considered right's violations. As issues have arisen, they have been handled on a situational basis either through policy clarification or through IP involvement.

There have been some situations in which staff clearly and adamantly opposed developing and running behavior management plans–even at the most basic reinforcement level. Staff cited that they are unable to offer the time it would take to take data and offer reinforcement–although the time it takes to work through a behavioral issue certainly seems more prohibitive than offering incentives in the first place. Staff also reported that they would be unable to 'purchase' reinforcers for individuals (the agency had no money for such items) and that 'free' reinforcers (like a ride to purchase a candy bar or pop) would put them out of compliance for Appendix I. Clearly there is misinformation regarding the purpose and intent of behavior management plans, as well as expectations for staff ratios. In the most extreme example of not wanting to run a program, staff was very frustrated that they were being mandated to do things that made their jobs impossible, that created extra, meaningless work and that overall made no difference since no one ever looked at the information or even cared whether it was done. While this may well have been just one person's opinion, it seems to reflect some of the frustration and maybe isolation felt in some of the homes.

Quarterly reports are an ongoing concern again this year. Cedar, Riverview, and SL were put on corrective action by QLC in April due to unacceptable quarterly reviews. Data was missing and/or never taken in some instances. During on site review of files, Treasure State also had "relief on duty" documented as a reason for lack of data on some consumer's programs. Timeliness of the reports as well as whether the data is meaningful and reflect actual progress are some of the issues that have surfaced during the course of this review period. Inter-agency meetings have been held to address concerns. It is unclear with the proposed changes in individual planning and service brokerage what form quarterly reporting will take. This may be an issue that works itself out in the new processes.

IP checklists as outlined in the QA handbook were used to sample components of consumer plans of care. A variety of assessments are used to determine strengths, needs and desires. Long range goals and objectives may not be related to assessed needs and are not always measurable in terms of outcome and intent. Objectives were not always implemented within the two-week time line despite the fact that with the change to contracted Case Management this year, IPs are generally back to the provider within a few days of the meeting. Long range goals may or may not reflect meaningful consumer driven wants or needs. Data is very well documented in some areas of the agency (Willow, Meadowlark) and sparse or missing components in other areas (Cedar, Ramuir, Primrose, see also supported living). During the large transition and movement of persons between homes, data was lost, programs were not implemented and in many cases, transitions were not followed. Agency staff have stated that programs could not be run due to the use of relief staff, staff shortages, lost data, lack of transfer of program books, etc...

Leisure and recreational activities are documented in house logs and data sheets on a regular basis; however, some activities are questionable. As noted in the last evaluation, going to the main office, running errands with staff, fleet maintenance, getting haircuts, buying groceries or medical appointments should not be documented as community recreational outings. Likewise, outings with family are a client right, not an agency reportable recreational opportunity.

Consumer involvement in their homes depends much upon the consumer's ability and the staff in the home. Some staff prefer much consumer involvement, even if it takes more time or more planning. In other homes, staff appear to prefer more control. We are only aware of 'house rules' in one home (Central), and it is clearly documented that the residents in that home had direct input and agreement in the making of those rules.

Consumer surveys from the Case Managers were generally available and did not indicate significant consumer dissatisfaction as a rule. It is believed that identified issues were addressed on an as needed basis. Additionally, QLC's internal satisfaction surveys showed similar results. Overall, the residents appear to be happy where they live and are involved in leisure activities of their choice, for those able to make choices. It is noted that the agency satisfaction surveys include pictures of Great Falls staff that may not be as meaningful to the consumers in Conrad and Shelby.

Staff at Treasure State group home did a wonderful job of transition for . The Group Home Manager in this site remained diligent, communicating with MDC to ensure his needs were met, and that appropriate objectives were set. Staff at MDC were concerned he would lose weight as a result of his move, but in fact he has gained weight and seems very happy in his new home. Transition for the five folks to Primrose from MDC was not without complications. Despite meetings with direct care staff to ensure a smooth transition, last minute agency decisions to pull those staff and put different staff in the home, created confusion and unnecessary hardships for all involved.

There have been two ports out of group home services and into other agencies this year. Both were based in the consumer wanting to get closer to family members in other parts of the State.

Medical/Health Care:
There are dental concerns in many group homes. More often than not the dentist reports that there is poor dental hygiene when he does this exam (this is also true for the supported living folks). There have been a couple of cases of severe periodontal disease, one of which resulted in hospitalization of the consumer. Also as previously mentioned, one home was found to have been falsifying medical reports. Aside from the obvious consumer related health issues, the agency also found it necessary to write new policy requiring the doctor or dentist to sign the medical report as proof the consumer received the service.

Emotionally Responsible Care Giving does not appear to be trained with the same regularity and intensity that was offered in previous years. Individual staff appear to be invested in consumers, while other staff appear content with care taking roles. There have been notable examples of excellence in caregiving in most of the homes, based on individual staff resources. Staff in various homes have recounted chipping in their own money, time and creativity to decorate homes, bring necessary items to consumers, and host social events that were joyful, respectful and consumer-centered.

SUPPORTED LIVING:
A total sample of 9 supported living consumers were reviewed, including Conrad and Shelby consumers. From direct observation and interviews with consumers, is apparent that most of the supported living staff members utilize emotionally responsible care giving. For example, three of the four supported living clients in Shelby were hospitalized during the past year. QLC staff managed to get them to their medical appointments in Great Falls and visited them in nursing homes and hospitals during their stays. Despite the numerous supported living staff changes in Conrad and Shelby, the services appear to remain constant.

Documentation appears to be an ongoing problem with supported living services provided by QLC in the northern areas as well as Great Falls. While completing file checks, it was common to find missing or inaccurate data. A memo was sent March 29th, 2005 by Lynn Morley stating formal corrective action has occurred with supported living staff due to outcome data for the third quarter. QLC management felt data was unacceptable. According to that memo, the issue was recognized and formal measures have been implemented to address it. Several of the supported living consumers' working files in Great Falls were missing and information had to be regenerated, creating gaps in data and potentially in service provision.
In Shelby and Conrad, progress notes, medical appointments and recreational outing documentation was noted to be written sometimes prior to the event taking place. As previously mentioned, the shortages of staff and sharing of staff between Great Falls and Conrad has sometimes created some gaps. This was evidenced in one supported living consumer's apartment where dried feces, mold, and filth created a substandard living environment. Medication errors (the consumer was taking all three doses of medication at one time) were also noted. The agency responded that the PCA should have been more responsible. In point of fact, the new PCA to that site discovered the issues–QLC staff were not aware. It appears there was a lack of supervision and/or communication between staff and supervisors. It could be the management structure of this department is not working. Information appears to be getting lost between/amongst the levels of staff. Again, staff have been shuffled around, no consistency has been maintained and quality of services suffered because of this. Most recently SL staff from Great Falls were pulling shifts at a group home in Conrad in order to ensure the Appendix I ratios were met. Unfortunately the consumers in SL in Great Falls did not receive their services/appointments during that time or had to be rescheduled when staff was available.

Comments expressed earlier regarding incident reporting also apply to the supported living program..

Satisfaction surveys are completed with each consumer prior to their IP meeting by the CM and QLC. Documentation is placed in the file with the IP. The surveys completed by the QIS with the consumers in the sample indicate most of the consumers are satisfied, partially if not totally, with the services they receive. One consumer felt all these questions were stupid. There were complaints about just getting used to a staff member and then having them transferred and another staff assigned. Another complaint was that staff do not come at scheduled times. Scheduling does appear to be an issue. It is not always the staff person's fault. The Developmental Disabilities Program recognizes that consumers also do not keep appointments. It does not appear however, from consumer reports, that QLC is able to accomodate consumer preferences for staff who work with them. This is in tandem with the CARF recommendation A.3 in the August 04 report.

The staff were surveyed and required prompts on reporting incidents. They felt they were adequately trained. Staff surveys again show a general lack of knowledge concerning incident reporting (when and to whom to report).

The same comments regarding individual plans apply to supported living, as mentioned earlier.

Two consumers ported out of QLC supported living services this year, one citing money management issues and the other citing a preference for activities/services offered by another provider. Four other consumers have considered

porting their funds, three of whom are currently still thinking about it. One consumer in Conrad was unhappy with his day service and redirected his dollars into supported living to better meet his needs.

WORK/DAY/COMMUNITY EMPLOYMENT:
QLC has two day program sites (Conrad Work Services and Great Falls Seniors). Under the current contract, QLC does not have the ability to provide intensive day services. Nor can the agency provide facility based day services to anyone in Great Falls that is not either Senior eligible, or served in supported employment. There has been some discussion about whether the agency would develop a work activity site that would benefit younger persons. Recently, the agency offered to provide 'recreational' services to a young woman who is aging out of Intensive Family Education and Support services. Part of the proposal is that the group homes and/or the senior day program could be used as 'changing' stations for this young woman in the event of incontinence during the day. While this proposal makes sense on the surface, it is unclear whether consumers living in the group homes will appreciate having someone in their home in their absence, or how that will look procedurally (do staff have access/keys to all homes, or will it be one site in particular?). Other questions have been asked about whether this young lady will be able to access activities at the senior day (presumably with senior day program staff) or whether it will be possible to provide structured activities outside of her home for several hours a day, five days a week. The agency is to be commended for their creativity in attempting to provide a truly individualized plan. No proposal or cost plan has been submitted to DDP for the service (supported living or work service).

Fire/emergency evacuation drills are conducted at least quarterly at each work/day site. Documentation was available at each site. Vehicles are maintained at regular intervals. Comments noted above regarding safety checks and periodic maintenance applies to all vehicles.

One consumer ported their money into QLC for work services, but has not yet gone to work.

Service Planning and Delivery:
Checklists are most frequently used in place of training objectives. The same basic information noted above applies to work services as well.

The CWAC on site review was held January 25, 2005. Disaster drills, attendance records, emergency procedures, and equipment checks/water temperature checks were reviewed. All appeared to be in order. The environment was clean and sanitary. Egress within the building was acceptable and it appears measures have been taken in the back where sorting is done to make it less hazardous. One consumer at the workshop has had frequent falls. A loose roll of toilet paper was found in the women's restroom and noted as a tripping hazard. The staff at the work activity center were informed of this during the on site visit. All fire extinguishers were checked and are current. QLC purchased new fire extinguishers in August 2004. Supplies seem to be adequate and were stored appropriately. The storeage area for cleaning supplies is cleverly put together.

The Conrad work activity center has been busy with packaging contracts. Other vocational opportunities include janitorial, the Two Times New thrift store, Russell Country mailings, and recycling. At times they were so busy with packaging, that some of the mailings were done at the senior day program in Great Falls. The work activity center staff tracks vocational activities as well as recreational/leisure activities. A copy of the codes was supplied to the Quality Improvement Specialist. A daily tally for vocational and leisure/recreation activities using the codes is completed for each consumer.

Medication procedures were reviewed. PRN medications were reviewed and protocols were found in the medication book. Medications were stored in a locked cabinet. Administration records for medications appear to be following policy; the staff people assisting with medications are certified to do so. A prescription for a caffeine restriction was discovered for one consumer, but no rights restriction was found with the IP.

The staff ratio was 4 to 16 and this meets the Appendix I contract ratio. The staff survey was completed successfully with prompts required for reporting procedures.

IP's were reviewed for the sample consumers. Just about all the consumers at the work activity center had some kind of work objectives. Findings from file reviews included the following: not all long-range goals and some objectives were not measurable, 1 objective was not started for the entire IP year, quarterlies were missing from some files, IP documents were not available to all staff, an internal monitoring process was not apparent for all IP's, and one consumer's book had the IP information from the previous two years but nothing current. It was previously noted that this person did not receive services from January 2005 until April 2005 due to transportation issues internal to QLC.

SENIOR DAY PROGRAM:
Seniors were actively participating in various activities at the time of the site review. Some were engaged in work (mailers), others were playing Bingo and still others were watching TV or waiting in the lobby to go home. It was interesting to note that two staff were actively involved with consumers while two other staff were completing paperwork and had no consumer involvement. Food was still out from lunch and the kitchen was not yet cleaned up. The water temperature exceeded 120 degrees (this is in part due to the dishwasher and it is noted that consumers have limited or supervised access to this sink) but barely raised 98 degrees in the bathroom. It is noted that the seam on the rug in the foyer is frayed and may create a tripping hazard. Individual plans for the seniors center on leisure and recreation, although several of the seniors are enjoying the extra work on the Russell mailers (out of Conrad). It appears that the seniors are being paid piece rate for this work and appropriate wage certificates are on file. IP comments from earlier in the report apply here as well. It is noted that all of the seniors have effectively the same IPP/checklist with each person's 'personal' preferences highlighted in terms of activities. This is indicative of personal choices among the activities offered as opposed to real individual planning. This seems to correlate to the CARF recommendation A.7.c and E.2.e (7) as noted in the August 04 report.

One consumer ported into the senior program, and later ported back out to Easter Seal this year.

SUPPORTED EMPLOYMENT:
QLC currently serves only a handful of consumers in supported employment services. One consumer served through supported employment has not had a job for the past year and no quarterly progress reports can be found in the file at the Developmental Disabilities office to know if any attempts were made toward employment. Measurable objectives were not clear in her IP and a checklist is used, which does not show what she has and has not done concerning her objectives. Another consumer stated he was dissatisfied with services. He states he found his own jobs and when he asked for help with job interviews he had to "fight with QLC" staff to help him. He also has no work objectives in his IP. He said, however, he likes his current Job Coach.

It appears no individual job coaching has been completed in Conrad for some time. It is noted that the agency is currently working on a contract to do janitorial for the APS office there. Additionally, the WAC consumers are able to earn income through the second hand store, the lentils contract, Russell Country mailers and the proposed new venture of packaging coffee beans.

One consumer is billed under a work services slot, and according to his IP has a job--but he shows no record of payment for that job. Staff report that he is paid under the table ($1or $2 for filling the pop machines), out of staff pockets. He also delivers mail between agencies and shows no recorded payments for this 'job.' For all appearances, these 'jobs' are 'permanent'–have been occurring beyond what would be considered 'training' time, and yet the agency does not have a sub-minimum wage certificate or wage and hours studies to support less than minimum wage. Since the agency benefits from his activity (someone else would either deliver the mail or fill the pop machines), he is performing a service that for all intent and purpose appears that it should be compensated. The agency appears to be out of compliance with Department of Labor regulations. (On 5/18/05, we were told that wage and hour studies were recently completed on this individual and that he should be getting payment beginning in April. When asked how back payment would be calculated, we were told that staff were attempting to ascertain the hours based on id notes. Because parts of this 'employment' have continued for longer than a year, it is recommended the agency consult DOL to ensure appropriate reimbursement is made).

It is also noted that the agency hired a supported living consumer in Great Falls to work as a staff person in one of the group homes. This referral was made through Vocational Rehabilitation but the question remains how a person receiving services can also provide services to his peers.

COMMUNITY SUPPORTS:
QLC has served 10 consumers in the community supports program this year. Three of these consumers are served in State General Fund; the others in Title XIX/Medicaid. Agreement and authorization forms are current. Some of the services QLC provides under this program include transportation, respite, recreation and leisure activities, supported living, community integrated activities, supported employment, education, residential and day habilitation. Case Managers completed satisfaction surveys with each recipient of community support services. IP meetings were held, checklists completed, and long-range goals and objectives were documented in the IP.

The reasons consumers are not satisfied include unkept promises (not meeting needs identified in the cost plan or IP), inconsistent staff contact, missing appointments (sometimes rescheduling but sometimes not), service hours at the convenience of the staff and not the consumer, changing assignments to another staff person, and financial issues. One family requested a running total for the community supports balances and Quality Life Concepts has not consistently followed through with meeting this request. Another family contacted a lawyer regarding items purchased by the family

and not reimbursed by Quality Life Concepts. But there is also speculation gift certificates were purchased with community supports money for this particular client. It is unclear whether this is a communication problem with the family and Quality Life Concepts or just the family trying to take advantage. In any event, the gift certificates are not something allowed under the wiaver and the CS agreement should have been followed. Quality Life Concepts should have been purchasing items specified in the agreement; the mother should not have been involved in this. This particular client has since ported his community supports to another provider.

The recipients who remain in Community Supports at Quality Life Concepts state they are satisfied with the services they receive. One consumer and her Guardian were very pleased with the services received; the Case Manager sent an e-mail to everyone to recognize the staff who works with them and how much they appreciate this particular staff person and the help they receive from her.

At the end March (75% of the fiscal year), cost plans have been expended at about 75 percent, indicating maximization of the cost plans. Throughout the year, four consumers have ported their services to another provider. One consumer who ported his money into QLC, left after three months, dissatisfied with services. This leaves a net of 6 consumers currently served.

III Recommendations and Conclusions:

There have been many changes in the developmental disabilities service system this past year. A new case management agency, changes in state policy and procedure, continued movement to rate setting and individualized service plans, as well as staff turnover in both the Regional office and at QLC have created a challenging year. The challenges facing us this next year will likely test our resources even further. For this reason, we would like to propose to following recommendations for the agency:

1. The agency needs to improve its communications both internally and with other agencies, family members, Guardians, etc... It is suggested that the agency consider the appointment of a liaison that can act as an authority in terms of contract and interagency issues as well as ensure that the departments within QLC have necessary information and are able to respond according to agency policy and in a manner that promotes effective team building and proactive strategies. It is also suggested that the agency consider a structure which will allow for more accountability in each program by limiting the continuous re-assignment of staff within the agency, and/or by ensuring that the person assigned to a particular program has the authority to hold staff accountable. A long term consideration might include whether the agency itself could be structured into smaller divisions, making it more manageable.

2. There appears to be concern from direct care staff regarding communication and the overall health of the agency. It is recommended that QLC consider the use of an unbiased, outside entity to conduct staff surveys to ascertain those concerns directly so that staff can speak freely and without fear of retaliation. The information may be useful in determining causes (other than wages) for staff turnover and/or dissatisfaction. In tandem to the CARF recommendation, the agency should ensure that its policy against retaliation is current and enforced.

3. We recommend that the agency find a way to effectively utilize internal QA processes to more proactive outcomes. One suggestion is to consider whether issues of follow-up might be resolved by having the QA staff work under Human Resources in order to eliminate the potential for disputes between departments (ie: residential vs vocational) and allow for the use of performance related consequences to ensure appropriate follow-up of identified/ongoing issues.

4. We are requesting an audit through the HHS Quality Assurance Division to reconcile concerns regarding individual consumer expenditures.

5. It is recommended that the agency review its current on-call procedures to ensure that the consumer needs are better met. It doesn't seem humanly possible for staff to know and be able to potentially respond to 144 different scenarios. It is suggested that QLC consider what kinds of issues an on-call staff can reasonably address, while appropriately assigning other responsibilities within existing staff structures or to supervisory positions that have a more complete working knowledge of those consumers or sites.

6. We recommend that the agency continue its endeavors in developing their incident report management committee and that they include stakeholders such as APS in the development of the procedural components of their policy.

7. It is recommended that the agency develop a pattern of training and promotion that limits the need for continuous reassignment of key personnel across program areas to allow for more accountability and consistency in the delivery of services. It is also recommended that the agency develop a training curricula, or a standardized set of policies that ensure that each level of supervision has skills greater than the preceding level.

8. It is recommended that the vocational services staff access Department of Labor workshops or resources to ensure compliance in wage and hour regulations, not limited to use of sub-minimum wage certificates, use of piece rate and when it is necessary to pay minimum wage.

9. It is recommended that the agency develop a realistic array of services that will enable them to be competitive while minimally disrupting services to current consumers. The use of creative, community accessible activities without reliance on existing facilities or the development of new vocational and recreational outlets is also recommended.

Change is always difficult and often stressful. We would especially like to thank the staff who were so very forthright in their responses to us during our review. We look forward to strengthened partnerships and continued pursuit of meaningful individualized services for our consumers. As always, we are happy to provide whatever assistance we are able in order to promote your continued endeavors.

cc: Community Services Bureau Chief
Regional Manager
Contract file

Attachments:
Observations Sheets numbered Q1-Q18
QLC CARF Report August 2004