2024

Quality Improvement Plan

Approved by the Board of Directors 4/8/2024

Position Statement

It is the position that Saratoga Bridges maintains this quality improvement plan in keeping with the Board of Governors of The ARC NY established in 2014.

We strive to maintain the highest level of quality standards that are reflected in a continuum of services and supports for the people we support on a daily basis, keeping in mind the essence of high satisfaction levels with our services with all stakeholders. This is evidenced by measurable outcomes and a continuous improvement process. This includes Person-centered service planning and delivery, community inclusion, protection and safety from harm, abuse, and exploitation consistent with the ARC NY's values.

This quality improvement plan is consistent with OPWDD's Agency Protocol manual and is designed to uniquely fit with Saratoga Bridges' culture, mission, vison for the future of service delivery as well as being adaptive to the challenges and strengths in our field. This quality improvement plan:

- **Supports our mission more than anything else, to empower individuals with intellectual disabilities and their families to identify and pursue their life goals through knowledge, collaboration, and experience.**
- **Supports our vision, enriching lives by providing opportunities and partnerships.**
- **Supports our values-Respect, Innovation, Teamwork and Excellence.**
- **Commits to a continuous quality improvement process that is supported by our agency policies and procedures.**
- **Is managed by key stakeholders, the People we Support, the Board of Directors, the CEO, COO and Director of QA as well as involvement with Human Resources, Finance, and all Program Directors.**
- **Outlines our systems for data collection, review and analysis for our goals and objectives.**
- **Includes objectives, measurable actions, and the expected outcomes.**
- **Identifies how the plan will be reviewed, revised, and approved on an annual basis.**
- **Identifies how this plan and progress with implementation will be shared with agency stakeholders.**

About Saratoga Bridges

Quick Facts about Saratoga Bridges

- 2023 Operating Budget – $23,940,954
  Revenue – $23,940,954
  Expenses – $23,928,009
  Net Surplus – $12,945
- Funding Sources – Medicaid 96%, State 3%, Miscellaneous 1% = 100%
- Individuals served – 830
- Employees – 414
- Volunteers – 185
- Interns – 5
- One of largest non-profit human services agencies and top employers in Saratoga County
- Families receiving in-home support – 298
- Individuals competitively employed in the community – 113
- Individuals participating in pre-vocational support – 23
- Number of individuals waiting for a residential placement – 138
- Number of people living in our 18 community-based homes – 116
- Number of people living in our 7 supportive apartments – 11
- Day Programs – 5 program sites throughout the county that support 215 people
- Transportation – 107 individuals transported daily to and from employment or programs

The Key Areas for Quality Improvement based on the ARC NY QSOC revised standards, 10/26/2023

The ARC NY has identified five (5) key areas for quality improvement that each chapter must address within their QIP (Quality Improvement Plan).

The five (5) key areas are:

1. **OPWDD Bureau of Program Certification (BPC) Survey Results.**
2. **Saratoga Bridges' Reportable and Significant Incident numbers, trends, outcomes, and effects on the people we support.**
3. **Self-Audits and Surveys / Peer Review Results.**
4. **Quality of Life and Satisfaction Survey Results.**
5. **Quality and Satisfaction Levels of Saratoga Bridges' workforce.**

Aside from these five key areas this plan also addresses the Governance role in the Quality Improvement process and plan development, review, and approval.

This plan also includes the requirement for an annual progress summary that identifies the quality improvement actions taken and the results/effectiveness.

This Quality Improvement Plan addresses the OPWDD "Topic 13" in the Agency Protocol Manual which outlines the following standards that must be met:

A. QI Plan Person-Centered Outcome Standards:

1. The quality improvement plan includes measurement, aggregation, and analysis of factors related to the outcomes and quality of life desired by individuals.

a) To meet this standard, there must be evidence to support that QI strategies include measurement and analysis of individuals' quality of life outcomes.

2. The quality improvement plan addresses person-centered planning and service delivery.

a) To meet this standard, the QIP must describe activities to address agency effectiveness in person-centered planning and service delivery.

B. QI Plan Health, Safety and Freedom from Abuse Standards:

3. The written quality improvement plan addresses assurance of individuals' health, safety, rights, and freedom from abuse/neglect and exploitation.

a) To meet this standard, the QIP must describe activities to address individuals' health, safety, rights, and freedom from abuse/neglect and exploitation.

C. QI Plan Compliance Standards:

4. The quality improvement plan includes OBJECTIVEs, objectives, and processes to address compliance with OPWDD, state and federal requirements.

a) To meet this standard, the QIP must include activities to address compliance with OPWDD, state and federal regulations. This includes strategies to assess and/or measure rates of compliance and/or factors influencing the compliance/non-compliance. Additionally, OBJECTIVE setting and systemic strategies related to maintaining or improving the level of agency compliance must be present.

D. QI Plan Satisfaction and Planning Standards:

The agency quality improvement plan addresses areas important to stakeholders based on their solicited input.

a) To meet this standard, the QIP must describe the way(s) in which stakeholder feedback is solicited and the process for review/analysis and consideration for inclusion in the QIP.

6. The quality improvement plan addresses findings from satisfaction surveys.

a) To meet this standard, the QIP must formally address findings from satisfaction surveys.

E. QI Plan Communication Standards:

1. The quality improvement plan is reviewed and approved by the board of directors on at least an annual basis.

a) To meet this standard, the agency must be able to show that review and approval of the QIP by the board of directors has occurred within the last year.

2. There is a mechanism for making the Quality Improvement plan known to the people supported, staff, agency stakeholders and other interested parties.

a) To meet this standard, the agency must be able to demonstrate that stakeholders have been informed of the agency QIP.

F. QI Plan Annual and On-Going Effectiveness Standards:

1. The agency's QI plan identifies quality improvement actions to be taken during the year.

a) To meet this standard, the QIP must describe the quality improvement actions to be taken during the period of the plan. These actions must include measures, analysis, implementation, and review

2. The agency's quality improvement activities include an annual progress summary that identifies the quality improvement actions taken and the results/effectiveness.

a) To meet this standard, the agency must complete an annual summary of the QIP describing actions taken and the results of those actions. This includes reflection on the significant and minor improvements/changes in quality, as well as the actions that appear to have had no impact, if any.

Section 1: OPWDD Bureau of Program Certification (DQI)

In 2023 the total number of OPDDD surveys was 39 and 14 of these surveys resulted in a formal plan of corrective action, referred to as a "POCA" (36%).

Although citations can be given and not result in a formal POCA, these are non-systemic issues and not egregious enough to result in a POCA. Although they are still considered citations, they are corrected with administrative and programmatic review.

Both types of citations and corrections are listed below for reference for the Quality Improvement OBJECTIVEs for 2024.

2023: Numbers and Trends

1/11/2023- Geyser Road

Two citations with Statement of Deficiency

- **Bathroom off kitchen had lock broken on door lock, therefore could not afford privacy.**
- **Two individual's bathrooms were found to have no heat**
-

Four Office of Fire Prevention and Control surveys- No citations.

One person- centered review – Community Hab- No citations

2/21/23- Locust Grove Road IRA

One citation with Statement of Deficiency

- **Medications are not secured as evidenced by non-medication certified staff accepting medication delivery at the IRA.**
-

2/15/2023- IRA Apartments, 6K Hollandale

Two citations with Statement of Deficiency

- **Fire evacuation drills are not completed in the intervals specified by OPWDD.**
- **Diabetic care cannot be verified as the individual has an injectable medication and it is unclear if she is capable of administration.**

2/24/2023- Juniper Place IRA

- **No citations**

3/1/2023- Loughberry Road IRA

No statement of deficiency

2/16/2023- Wilton Day Hab

- **No citations**

2/15/23- Alpha Day Hab HCBS validation visit

- **No citations**

3/22/23- Grooms Road IRA

- **Statement of Deficiency for the site not ensuring in-home routine support for health needs are met.**
- **Evidenced by Bowel Management not being tracked.**
- **Evidenced by medications not being signed for.**

4/5/21- Finley Road IRA

- **Statement of Deficiency for Plan of Nursing Support Services (PONS) not matching MD orders for fluid restriction.**

Physical plant citations for flooring throughout being worn, a trip hazard on the sidewalk where the pavement buckled and chips on the kitchen counters,

4/6/23 – East Ave Day Habilitation left side.

- **HEALTH SUPPORT & MEDICATIONS: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services. Decision not met – internal Exit Conference (No SOD)**
  Rationale Based on staff interview on 4/6/23, it cannot be verified that a Registered Nurse (RN) is immediately available to provide supervision

for staff responsible for administering medication. Specifically, an interview with the Assistant Director of Day Services and with the Day Habilitation Instructor revealed that the facility does not have an assigned RN providing supervision/oversight for Approved Medical Administration Personnel (AMAP), nor is there an assigned RN that the staff would call in case of emergency or clarification of a medical directive. Therefore, it could not be verified that medical or nursing supervision of those staff responsible for administering medication is being provided.

4/6/23- East Ave Day Habilitation, right side.

- **HEALTH SUPPORT & MEDICATIONS: Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals. Decision not met – Internal Exit Conference (No SOD)**

  Rationale Based on review of the Approved Medical Administration Personnel (AMAP) certifications of direct support staff and an interview with the Director Support Staff on 4/6/23, the agency did not ensure that staff was certified to administer medication. Specifically, it was discovered that the AMAP Certification for one staff member had expired on 3/31/23 and was not recertified. A review of the Medication Administration Records (MARs) and interview with the staff members revealed that medications were administered on 4/3/23, 4/4/23, and 4/5/23. In addition, it was identified through interview with the Day Habilitation Instructor and the Assistant Director that the program does not currently have a Registered Nurse assigned to the program. Therefore, it could not be verified that the agency is ensuring that certified staff are administering medications.

4/6/23- Ruggles Road ICF – Six-month revisit

- **No citations, all previously deficiencies found to be corrected.**

Washington Street ICF- OFPC fire inspection survey- 6/26/23

K 000

A life safety code survey was conducted on 6/26/2023. This facility is required to meet all of the applicable provisions of the 2012 Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA 101). This facility has not met all of the applicable provisions of the 2012 Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA 101) at the time of survey.

K324

The facility is requesting an exception to this deficiency based on the following regulatory references:

19.3.2.5.1 – Cooking facilities shall be protected in accordance with 9.2.2 unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3 or 19.3.2.5.4

9.2.3 – Commercial cooking equipment shall be in accordance with MFPA 96, *Standards for ventilation Control and Fire Protection of Commercial Cooking Operations, unless installations are approved existing installations which shall be permitted to be in continued service.*

NFPA 96 1.1.4- This standard shall not apply to facilities where all the following are met:

(1) Only residential equipment is being used

(2) Fire extinguishers located in all kitchens are in accordance with NFPA 10, Standards for Portable Fire Extinguishers

(3) Facility is not an assembly occupancy

(4) Subject to the approval of the authority having jurisdiction

Completion date: 7/21/2023

Malta Avenue. 6/27/23

S 2a : HEALTH SUPPORT & MEDICATIONS
Standard 2a-11: The site ensures that in-home, routine support/care necessary for individuals' health needs
is provided per their service plan.
Decision not met - ECF - SOD
Rationale Based on a review of Individual 1045889's Plans of Nursing Services (PONS)on 6/27/23 it was
identified that the PONS were not reviewed at least annually as required. Specifically, a majority
of the PONS were most recently reviewed on 8/16/21. Therefore, it cannot be verified that
Individual 1045889's health needs are provided per the service plan.
It should be noted that this is a repeat deficiency –

4-9: The home takes timely action to provide requesting individuals with independent access to
their home and/or bedroom.
Decision not met - ECF - SOD
Rationale Based on record review and interviews with Individual 60750 and the Quality Assurance
Specialist on 6/27/23, it was identified that the facility did not take timely action to provide
independent access to the individuals to their bedrooms and home. Specifically, it could not be verified through documentation that the individuals were assessed on
their ability to have keys to their bedrooms or home. An interview with the Quality Assurance
Specialist verified that at the time of survey, key assessments have not been completed at this
residence. In addition, an interview with Individual 60750 revealed that he/she would like a key
locking mechanism for their bedroom door.

10e-3: There is documentation/tracking of the person's fluid consumption.
Decision not met - ECF – SOD
Rationale Based on a review of Individual 104589's Physician's Orders, dated 6/8/23, it was identified that

Individual 104589 requires a fluid restriction of 1600ml/day, which includes a fluid schedule. A subsequent review of data from January 2023 through June 27, 2023 revealed that staff are not consistently recording how much fluid Individual 104589 receives. It was identified that of the timeframe reviewed, there are zero instances where 1600ml of fluid have been recorded. This was confirmed with the Assistant Director. Therefore, it cannot be verified through documentation that Individual 104589 receives the required amount of fluid as prescribed.
It should be noted that this is a repeat deficiency

Middle Grove – 7/13/23

No deficiency

8/25/23- Remote Review- 151 Jefferson St. Apt. 52B

No Deficiency

9/5/23- Remote Review- Meadow Rue

No Deficiency

Meadow Rue – Remote survey 9/6/2023

No deficiencies

Graves Road- Partial Remote Review 9/21/23

Based on a review of the site Fire Evacuation Plan, dated 7/28/23, it was identified that staff are directed that "The first floor will be evacuated after the individuals on the Second Floor are moving towards the exit" as the

"second floor would be evacuated first", instead of evacuating the individuals in immediate danger first. Additionally, a review of the Site Plan of Protection revealed that the minimum staff on each shift (day, evening, and night) is 1. The fire evacuation plan indicates that the evening and weekend shifts have a minimum of 2 staff on duty. Therefore, it cannot be verified that the fire evacuation plan is acceptable.

Survey Clifton Park Day Hab 11/7/23- – SOD for Rights Protections. 9 out of 13-bathroom doors did not have lockable mechanisms. This is a federal HCBS mandate and is mandatory SOD. POCA submitted and we are awaiting approval.

11/8/23 – Six remote Day Hab surveys- No citations

Malta IRA 11/20/23- Cites for personal fund not reflecting cash amounts in house, citation for an individual's med monitoring plan needing to be a behavior support plan due to SCIP interventions, citation for SCIP not being incident reported, there were two individuals without the HCBS required Occupancy agreement (Statement of Deficiency) , citation for rights limitation as there was no behavior plan for one individual, citation for the plan not outlining interventions for staff to follow an document, cite for HRC not approving the plan with restrictive interventions, cite for the behavior plan supports not being provided as written.

11/28/23- Ruggles Road ICF full survey with DOH- NO Citations

12/6/23- Washington Street ICF revisit- NO citations.
Wilton Day Hab; 12/20/23- These HCBS (Home and Community Based Services) deficiencies were previously overlooked and issued on an ECF. Therefore, BPC (Bureau of Program Certification) is now being issued as a SOD (Statement of Deficiencies) which requires a POCA (Plan of Corrective Action).

1) 4: FULL ACCESS TO THE COMMUNITY
Standard 4-1: The individual is encouraged and supported to have full access to the community based on
their interests/preferences/priorities for meaningful activities to the same degree as others in the
community.

Decision not met - SOD
Rationale Based on documentation review and interview with the Assistant Director on 2/16/23, it could not be verified that Individual 52408 is encouraged and supported to have full access to the broader community.
Specifically, a review of the "Day Pro/Community" forms from 10/1/22 to 2/15/23 revealed that Individual 52408 participated in 2 community outings. In an interview, the Assistant Director reported that Individual 52408 is offered the opportunity to participate in community activities every week, but they refuse.
However, it could not be verified through documentation that Individual 52408 is offered, encouraged, and supported to have full access to the community.

2) 4-2: The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.
Decision not met - SOD
Rationale Based on documentation review and interview with the Assistant Director on 2/16/23, it could not be verified that Individual 52408 is encouraged and supported to have full access to the broader community.
Specifically, a review of the "Day Pro/Community" forms from 10/1/22 to 2/15/23 revealed that Individual 52408 only participated in 2 community outings. In an interview, the Assistant Director reported that Individual 52408 is offered the opportunity to participate in community activities every week, but they refuse.
However, this could not be verified through documentation that Individual 52408 is offered or participates in unscheduled and scheduled community activities on a regular basis.

Stone Church IRA; 1/3/24- Exit conference form, no SOD
2a: HEALTH SUPPORT & MEDICATIONS

Standard 2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs. Decision not met - ECF Rationale Based on record verification and interview with program staff on 1/3/2024, it cannot be confirmed that individuals' medications and treatments have been correctly administered per physicians' orders. Specifically: 1. Individual 69337's Medication Administration Record (MAR) for November and December 2023 identifies Milk of Magnesia (MOM) 30 ml is to be given by mouth every day as needed if no Bowel Movement (BM) in 3 days. A review of Individual 69337's bowel tracking in Therap discovered the following: In November 2023, the Individual went more than three (3) days with no BM on 2 separate occasions and MOM was not administered per the order. In December 2023, the Individual went more than three (3) days with no BM on 4 separate occasions and MOM was not administered. 2. During a review of medications, it was discovered that Individual 151554 has an order for PRN Meclizine HCL for vertigo and nausea. This medication was not available on site for administration, if necessary. On the day of the survey, program staff called the pharmacy and were informed the script was out of date and a new script needed to be obtained before it could be filled. Consequently, it cannot be verified that individual's medications are administered in a manner that ensures the health, safety, and well-being of the people we serve

8: FIRE SAFETY (REQUIRED BY OFPC (Office of Fire Prevention and Control) (Office of Fire Prevention and Control) OR DQI (Division of Quality Improvement))
Standard 8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements. Decision not met - ECF Rationale Based on record verification and interview with the program staff on 1/3/2024, fire drills are conducted to effectively train and assess participants, per OPWDD requirements. Specifically: A review of the fire evacuation plans for the 2023 calendar year revealed that Individual 151554 refused to evacuate during overnight drills on two separate occasions. There is no evidence that the agency administrative staff addressed these issues within 24 hours, such as conducting repeat drills and/or consumer counseling. Per interview, the administrative staff were unaware of the refusals

8-5: OBJ The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements. Decision not met - ECF Rationale Based on record verification and interview with the program staff on 1/3/2024, it cannot be assured that the effectiveness of the fire evacuation plan

is monitored by agency personnel per OPWDD requirements. Specifically: OPWDD requires unannounced observation of evacuation and fire drills by administrative staff to be conducted at each supervised home, a minimum of once per year on the overnight shift, and once per year on a shift chosen by the agency. A review of the fire evacuation plans for the 2023 calendar year revealed that only one administrative oversite drill was conducted on an overnight shift. No other unannounced administrative drill was conducted. Furthermore, it was revealed that Individual 151554 refused to evacuate during overnight drills on two separate occasions. There is no evidence that the agency administrative staff addressed these issues within 24 hours, such as conducting repeat drills and/or consumer counseling. Per interview, the administrative staff were unaware of the refusals. Consequently, it cannot be verified that the facility provides adequate oversight to ensure that the information contained in the fire drill plan and the drill reports is consistent with the staff and individuals observed performance.

Ruggles Road ICF (Intermediate Care Facility), visit from DQI
E 000 Initial Comments E 000 A review of the emergency preparedness plan was conducted at Saratoga County, NYSARC Inc., 188 Ruggles Road, Saratoga Springs, NY 12866 on 11/30/2023. No regulatory deficiencies were identified. W 000 INITIAL COMMENTS W 000 A focused fundamental survey was conducted at Saratoga County, NYSARC Inc., 188 Ruggles Road, Saratoga Springs, NY 12866 on 11/28/2023 - 11/30/2023. The census at the time of the survey was eleven. Three residents were selected to be in the original sample. No regulatory deficiencies were identified.

Ruggles Road, Visit from OFPC.

K 000 INITIAL COMMENTS K 000 A life safety code survey was conducted on 12-18-2023. This facility is required to meet all of the applicable provisions of the 2012 Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA 101). This facility has not met all of the applicable provisions of the 2012 Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA 101) at the time of survey. K0712 Fire Drills CFR(s): NFPA 101 Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually, evacuate clients during at least one drill each year

on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code
3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR (Code of Federal Regulations) 483.470(i) This STANDARD is not met as evidenced by: During surveying activities, documentation review and walkthrough on 12-18-2023 with the Residential Manager 3 at approximately 0830hrs, it was determined that, 1-The fire drill that was documented for 05-15-2023, listed the drill as an evening drill and the drill time listed was 2158hrs. Upon discussion with the Residential Manager, this was a night shift drill, and the error was not identified or corrected during the administrative review. 2-The is a no documentation of the third drill for the second quarter of 2023. The only drills documented occurred on 04-16-2023 at 1002hrs and 05-15-2023 at 2158hrs. Upon discussion with the Residential Manager, this was not identified or corrected during the administrative review. This was confirmed with the Residential Manager 3 at the time of inspection.

K0741 Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2
This STANDARD is not met as evidenced by: During surveying activities, documentation review and walkthrough on 12-18-2023 with the Residential Manager 3 at approximately 0830hrs, it was observed that, located in the bushes and mulch adjacent/left of the front door and porch overhang, were multiple discarded cigarette butts. This was confirmed with the Residential Manager 3 at the time of inspection.

Washington St ICF; 12/6/23

INITIAL COMMENTS {W 000} A post certification visit was completed on 12/6/2023 at NYSARC, Saratoga County 64 Washington Street Saratoga Springs, NY 12866. All deficiencies have been corrected.

12/11/22 Wilton Day Hab Person-Specific Survey:

Section 4 : FULL ACCESS TO THE COMMUNITY

Standard 4-1: The individual is encouraged and supported to have full access to the community based on

their interests/preferences/priorities for meaningful activities to the same degree as others in the

community.

Decision not met - SOD

Rationale See standard 4-2

Reference 441.301 (C)(4)(i)

Citation The setting is integrated in, and facilitates the individual's full access to the greater community

including opportunities to seek employment and work in competitive integrated settings, engage in

community life, control personal resources, and receive services in the community, to the same

degree of access as individuals not receiving Medicaid HCBS.

Standard 4-2: The individual regularly participates in unscheduled and scheduled community activities to

the same degree as individuals not receiving HCBS.

Decision not met - SOD

Rationale Based on record verification and interview with the program staff on 12/8/2022, it was discovered

that Individual 49746 does not regularly participate in unscheduled and scheduled community

activities to the same degree as individuals not receiving HCBS. Specifically:

Individual 49746 started attending this day program again (after the pandemic) on 8/22/2022,

Monday through Friday. A review of the documented community outings for the month of

August through December 2022, revealed that this Individual participated in one (1) community

activity. Per staff interview, this Individual is transported to this program via the day program's

transportation and does not arrive until 10:00am and then leaves to go back home at 1:00pm.

Therefore, per the Day Habilitation Program Coordinator, due to the limited time the Individual

spends onsite at the day program (approximately 3 hours per day) as well as a lack of staff

resources, it is difficult to plan community activities.

Reference 441.301(C)(4)(i)

Citation The setting is integrated in, and facilitates the individual's full access to the greater community

including opportunities to seek employment and work in competitive integrated settings, engage in

community life, control personal resources, and receive services in the community, to the same

degree of access as individuals not receiving Medicaid HCBS.

A review of the survey results of 2023 shows that there are two trending factors that need improvement. Those are

1) **Health Support and Medications and**
2) **HCBS Settings Rules, specifically privacy, locking mechanisms available on doors and access to the broader community in both the residential and day programs.**

OBJECTIVE #1: Decrease the number of citations in the realm of Health Support and Medications in the 2024 and beyond survey cycle to zero citations.

MEASURES:

1) **The agency will track recruitment of nursing vacancies quarterly and aggressively recruit to fill vacancies. HR by 12/31/24.**
   This is to ensure that each person has adequate RN oversight.
2) **The Coordinator of Medical Services will train each RN that has a residential caseload in the OPWDD regulations and expectations for RN oversight to reduce the # of citations. This training will be conducted quarterly at RN meetings. Coordinator of Medical Services, by 12/31/24.**
3) **QA and Compliance will conduct quarterly mock DQI audits using the OPWDD protocols and will relay findings to program nursing and administration. Any deficient practice will require an immediate plan of correction. QA will conduct surveys quarterly. Dir QA by 12/31/24.**

OBJECTIVE #2: Decrease the amount of HCBS settings citations to zero citations in 2024.

MEASURES:

1) **QA will retrain all middle managers bi-annually on the HCBS settings policy and will work with Program Coordinators, Hab Coordinators, Res Managers and Assistant Directors to identify opportunities to implement ways to provide privacy, community opportunities and documentation that reflects our commitment to these standards. Director QA by 6/30/24 and 12/31/24.**

2) **The Assistant Directors will review individual community participation on a monthly basis and problem-solve with administration on how to effectively implement strategies with limited resources (Staffing in particular). Monthly by Assistant Directors, by 12/31/24.**

3) **The agency will track recruitment of DSP vacancies quarterly and aggressively recruit to fill vacancies. HR by 12/31/24.**
   This is to ensure that each program is sufficiently staffed to provide the support needed for full implementation of the Settings Rule.

Section 2: Reportable Incidents including Allegations of Abuse, Neglect and Mistreatment

Injuries

It is the intent of SARATOGA BRIDGES to ensure that all individuals who receive services do so in an environment that is as safe as possible and are protected to the extent possible from any potential danger or abuse.

Incident management is the formal system established to do so.

Therefore, the process of reporting and reviewing of incidents must work to ensure that necessary and prompt steps are taken to protect these individuals and others. It must initiate a response to dangerous or abusive situations, as well as attempt to eliminate the potential for future recurrences. We are committed to the enhancement of the quality of support.

Our incident management trend report for 2023 shows that we had 27

Allegations of abuse and neglect with four (4) being substantiated.

We investigated 45 Significant incidents in 2023, which would be in mistreatment or "other significant incident" and six (6) injuries.

The program that had the highest number of incidents was Birchwood IRA We attributed this to lack of consistent management at both the manager and assistant manager levels, inconsistent staffing and use of subs or "floating" staff and this coupled with a degree of high medical and behavioral issues coexisting in this residence.

Although we strive for zero incidents, allegations and reports of staff misconduct we realize that situations do occur that require the agency to immediately protect people, conduct a thorough investigation and to have the special review committee (SRC) oversee this process to ensure transparency, adherence to the regulations and requirements pertaining to incident management and to ensure that our policies and procedures are always in place and updated to reduce and eliminate incidents.

OBJECTIVE #3: Reduce the number of *substantiated* reports of allegations of abuse, neglect, or mistreatment to zero percent by 12/31/24 and beyond.

MEASURES:

1) **To maintain our workforce at 100% currently trained in rights, abuse, and incident reporting throughout the year. Staff Development will run reports quarterly to track our rates and reach out to those managers who are in need of signing their staff up for training or retraining. Staff Development will also ensure that program management knows how to run the training reports and keep their staff fully trained at all times. Staff Development, quarterly by 12/31/24**
2) **The agency will track recruitment of DSP vacancies quarterly and aggressively recruit to fill vacancies. HR by 12/31/24.**
   This is to ensure that each program is sufficiently staffed to provide the support needed to ensure consistency, familiarity with the individuals supported and less need to float, or sub staffing.
3) **The QA department will track all minor reports as well as all allegations and reportable incidents on a monthly basis and use the trending to provide immediate information, training, support, and action plans to reduce the number of reports.**
   QA Department, monthly by 12/31/24.

OBJECTIVE #4: Reduce the number of injuries (as defined in Part 624 as "Any injury that requires treatment above first aid") to zero in 2024.

MEASURES:

1) **To ensure that each person's plan of protection is kept up to date with safeguards, correct level of supervision and other important medical safeguards well defined.**
   Program Coordinators, monthly and as needed, by 12/31/24.
2) **Residential Managers to keep staff trained in individual IPOPS and other important safety documents (Behavior Plans, Dining Fact Sheets, Mobility Fact Sheets) by reviewing them quarterly with staff at staff meetings.**
   Residential Managers of ADRS, by 12/31/24.

3) **The QA department will track all minor reports as well as all allegations and reportable incidents on a monthly basis and use the trending to provide immediate information, training, support, and action plans to the programs to reduce the numbers of reports.**
QA Department, monthly by 12/31/24.

This written quality improvement plan addresses assurance of individuals' health, safety, rights, and freedom from abuse/neglect and exploitation and sets forth these activities to address individuals' health, safety, rights, and freedom from abuse/neglect and exploitation.

Section 3: Self-Audits, Surveys and Peer Review Results

This quality improvement plan includes objectives, and processes to address compliance with OPWDD, state and federal requirements.

This includes strategies to assess and/or measure rates of compliance and/or factors influencing the compliance/non-compliance. OBJECTIVE setting and systemic strategies related to maintaining or improving the level of agency compliance are represented here.

Saratoga Bridges is committed to fostering a culture of compliance through the implementation of a system for the routine identification of compliance risk areas to detect, correct and prevent non-compliance behaviors. Through the process of our corporate compliance reporting structure, the articulation of compliance-related roles and responsibilities at every level of the Saratoga Bridges' operations, and through the utilization of our organizational experience, detection and correction of problems is expedited. If an internal investigation substantiates a reported violation, then it is our policy to engage in a two-fold process:

(1) to initiate corrective action, including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, instituting whatever disciplinary action is necessary; and

(2) implementing systemic changes to prevent a similar violation from recurring in the future.

Saratoga Bridges is committed to routinely conducting internal audits of compliance risk areas. Results of internal and external audits are shared at minimum with the CCC and Saratoga Bridges Board of Directors. Saratoga Bridges also conducts annual reviews of the compliance program to determine and evaluate the program's effectiveness and any need for correction or revision. The results of annual compliance program reviews are shared at minimum with the CEO, senior management, the CCC, and the Board of Directors.

Saratoga Bridges maintains a compliance workplan that at minimum describes in detail the plan for routine auditing monitoring, and compliance program review activities. This workplan is drafted and/or developed by the CO and shared with the CCC for feedback. Revisions are made to the workplan as risk areas change and based on the outcomes of the auditing and monitoring activities.

Compliance conducted several audits and investigations in 2023 with Community Habilitation (aka "Comm Hab") being the program at highest risk for staff misconduct and Medicaid billing issues. This is due to the nature of staff working independently without direct supervision and the possibility of staff not carrying out the comm hab plans but documenting that they had.

In 2023 we saw three different Community Hab cases that were investigated by Compliance where it was shown that staff were behaving in ways that overbilled Medicaid for time and services, which were all corrected with OMIG self-Disclosures. These were settled with the OMIG.

Our 2024 Compliance Work Plan has at the top of its audit risk area, Community Hab. We were fortunate to obtain the services of another Compliance Coordinator, Heather Franke, in 2024.

With Community Hab being such a substantial risk for the agency, we have an OBJECTIVE to maintain checks and balances on the staffing, billing, and payments to the Comm Hab Program in 2024 and have zero compliance issues.

OBJECTIVE # 5: Reduce the number of compliance related issues in the Community Habilitation /Family Support Program to zero by 12/31/24 as defined by the OMIG audit tool.
MEASURES:

1) **The Compliance Coordinator will conduct a 100% audit on the Community Habilitation documentation, claims and billing for 2024 both in the beginning and end of the year to ensure 100% compliance (as the life cycle for Life Plans is every six months).**
   Compliance Coordinator, biannually by 12/31/24.

For Program Certification:

In order to remain in compliance with Federal, State, and local regulations as well as compliance with ARC NY policies and procedures, QA and Compliance will conduct quarterly mock DQI audits using the OPWDD protocols and will relay findings to program nursing and administration. Any deficient practice will require an immediate plan of correction. QA will conduct surveys quarterly. Dir QA by 12/31/24.

Section 4: Quality of Life and Satisfaction of the people we support

This quality improvement plan includes measurement, aggregation, and analysis of factors related to the outcomes and quality of life desired by individuals by examining satisfaction surveys, life plan and staff action plan

reviews and documentation of monthly notes which indicate individual outcomes and satisfaction.

To meet this standard, there will be evidence to support that QI strategies include measurement and analysis of individuals' quality of life outcomes.

The quality improvement plan addresses person-centered planning and service delivery.

OBJECTIVE #6: Demonstrate that family input and satisfaction surveys impact person-centered planning and service delivery in at least 90% of response rate, as demonstrated by involvement in the Life Plan and Staff Action Planning process.

MEASURE: QA will review 100% of the response rate of surveys and compare it with the Life Plans and Staff Action Plans (with input from the Program Coordinators) to ensure that input is included in the plans to determine total percentage rate.

OBJECTIVE #7: Demonstrate that 100% of individual input from satisfaction surveys are incorporated into the Life Planning process.

MEASURE: QA will review 100% of the response rates from individual satisfaction surveys (With input from the Program Coordinators) and ensure that 100% of the responses are included in the Life Planning process, and documentation exists to verify outcomes. Documentation may be in the form of the Life Plan, monthly notes, six-month habilitation summaries, or other forms of verification.

To meet this standard, the QIP has described activities to address agency effectiveness in person-centered planning and service delivery.

This quality improvement plan supports our mission more than anything else, to empower individuals with intellectual disabilities and their families to identify and pursue their life goals through knowledge, collaboration, and experience.

OBJECTIVE #8: Demonstrate that the Mission of Saratoga Bridges is fulfilled by staff for all individuals served in 100% of plans sampled.
MEASURE: The QA Department will review Life Plans, Staff Action Plans and Community Outing ISP data in Therap for a 10% sample in each program area quarterly to determine if the mission of pursuing life goals is evident.
QA Department, quarterly.

OBJECTIVE #9: Demonstrate that the Vision of Saratoga Bridges is fulfilled by staff for all individuals served in 100% of plans sampled.
MEASURE: The QA Department will review Life Plans, Staff Action Plans and Community Outing ISP data in Therap for a 10% sample in each program area quarterly to determine if the Vision of enriching lives by providing opportunities and partnerships.
QA Department, quarterly.

Section 5: Quality and Satisfaction Levels if the Chapter's Workforce

To offer an Array of Support, Learning, and Growth Opportunities that Assist and Engage Employees

OBJECTIVE #10: Conduct an employee survey that focuses on employee interests in training/educational opportunities so staff may advance in their careers

Review by training department of current curriculum and courses to identify opportunities for updates or improvement	**HRD**	**ongoing**

Survey employee population for educational opportunities desired	**HRD**	**August 2024**

Identify talent within the Agency and provide mentorship & development for succession planning.

HR Director, Annually or more as determined by HR

Section 6: Review, Revision and Approval of this QIP

- **Identifies how the plan will be reviewed, revised, and approved on an annual basis:**

  This quality improvement plan will be reviewed by QA on at least a quarterly basis to determine if the measures and objectives are being implemented and remain appropriate. QA will document reviews on the plan.

  This plan will be reviewed annually by the Board of Directors for their input, direction, and approval. The resolution to approve the plan will be included in the Board of Directors meeting minutes.

  This plan will be submitted to the ARC NY on an annual basis, post Board approval with the attestation of review by the Board. QA shall keep a copy of this attestation with the plan on file.

- **Identifies how this plan and progress with implementation will be shared with agency stakeholders.**

This quality improvement plan shall be made available on the agency website and at the time of conducting family and individual surveys we will provide information on how to access the plan. We shall direct all stakeholders to contact the QA Department with any questions, concerns, or additional information they would like to see measured in future revisions of the plan.

- **Is managed by key stakeholders, the People we Support, the Board of Directors, the CEO, COO and Director of QA as well as involvement with Human Resources, Finance, and all Program Directors.**

  This plan will be reviewed with the Board of Directors, Senior and Middle Management and will have input across agency-wide departments on an annual basis post Board approval. Meeting minutes shall reflect this review.

Section 7: Annual Progress Summary

The agency's quality improvement activities shall include an annual progress summary that identifies the quality improvement actions taken and the results/effectiveness.

This annual summary shall be reviewed by Senior Leadership as well as Middle Management and reviewed annually by the Board of Directors.

Quality Assurance will complete an annual summary of the QIP describing actions taken and the results of those actions. This includes reflection on the significant and minor improvements/changes in quality, as well as the actions that appear to have had no impact, if any.

Other ARC NY Quality Metrics that are tracked and entered into the Chapter Information System (CIS) on a quarterly basis with some annual numbers as well. These are:

Annual Quality Scores

Employee Injury

Annual # of injuries to employees (per 100 employees)

Employment Rate %

Annual % of individuals competitively employed

Staff Turnover

Annual % of full/part time employees who exited employment

DSP Vacancy %

Annual % of DSP positions that were vacant

DSP Turnover %

Annual % of DSP positions that turned over

BPC SOD %

Annual % of BPC surveys that resulted in an SOD

OFPC SOD %

Annual % of OFPC surveys that resulted in an SOD

OFPC SOD not FSES %

Annual % of OFPC surveys not met by FSES

Abuse Allegations

Annual # of abuse/neglect allegations (per 100 individuals)

Substantiated Abuse

Annual # of substantiated abuse/neglect cases (per 100 individuals)

Injuries per Individual

Annual # of injuries to individuals (per 100 individuals)

Frontline Management Vacancy %

Frontline Management Turnover %

ICF ER Visit %

IRA ER Visit %

Quality Scores

Employment Rate %

Quarterly % of individuals competitively employed

BPC SOD %

Quarterly % of BPC surveys that resulted in an SOD

OFPC SOD %

Quarterly % of OFPC surveys that resulted in an SOD

Substantiated Abuse

Quarterly # of substantiated abuse/neglect cases (per 100 individuals)

Staff Turnover %

Quarterly % of full/part time employees who exited employment

YTD Staff Turnover %

YTD % of full/part time employees who exited employment

DSP Vacancy %

Quarterly % of DSP positions that were vacant

DSP Turnover %

Quarterly % of DSP positions that turned over

DSP Turnover % (0-180 days)

Quarterly % of DSP positions that turned over within the first 180 days of employment

DSP Turnover % (181-364 days)

Quarterly % of DSP positions that turned over between 181-364 days of employment

YTD DSP Turnover %

YTD % of DSP positions that turned over

Front Line Management Turnover %

Quarterly % of Front-line Management staff who have exited the position

YTD Front Line Management Turnover %

YTD % of Front-line Management staff who have exited the position

Front Line Management Vacancy %

Quarterly % of Front-Line Management positions that were vacant

ICF ER Visit %

Quarterly # ICF ER Visits (per 100 individuals)

IRA ER Visit %

Quarterly # IRA ER Visits (per 100 individuals)

By:

Stephen R. Ramos

Director of Quality Assurance and Corporate Compliance

January 25, 2024