MASSACHUSETTS DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

Program Quality Assurance Services

PROGRAM REVIEW

CORRECTIVE ACTION PLAN

Special Education Agency: Italian Home for Children Program Review Onsite Year: 2020-2021

**Programs under review for the agency:**

**A - Italian Home for Children Day Program**

**B - Italian Home for Children Residential Program**

*All corrective action must be fully implemented and all noncompliance corrected as soon as possible and no later than one year from the issuance of the Program Review Final Report dated 05/24/2021.*

Mandatory One-Year Compliance Date: 05/24/2022

Summary of Required Corrective Action Plans in this Report

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| **Criterion** | **Criterion Title** | **Applies To** | **PR Rating** |
| PS 5.2(a) | Contracts | A | Partially Implemented |
| PS 9.4 | Physical Restraint | A,B | Partially Implemented |
| PS 11.3 | Educational Administrator Qualifications | A,B | Not Implemented |
| PS 12.2 | In-Service Training Plan and Calendar | A,B | Partially Implemented |

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| **Criterion & Topic:**PS 5.2(a) Contracts | **PR Rating:**Partially Implemented |
| **Applies To:**A - Italian Home for Children Day Program |
| **Department Program Review Findings:**A review of student records indicated that written contracts between the placing school district and out-of-district placement are not consistently signed by the placing school district. |
| **Description of Corrective Action:**Bi-monthly File audit of newly enrolled and returning students. |
| **Title/Role(s) of Responsible Persons:**Head of School | **Expected Date of Completion:** 10/01/2021 |
| **Evidence of Completion of the Corrective Action:**All contracts signed as required. For any unsigned documents, there is documentation of efforts to obtain signatures |
| **Description of Internal Monitoring Procedures:**The Head of school will conduct bi-monthly audits of all student records to make sure that all required signatures have been obtained and a plan in place to secure outstanding signatures. |
| **CORRECTIVE ACTION PLAN APPROVAL SECTION** |
| **Criterion:**PS 5.2(a) Contracts | **Corrective Action Plan Status:** Partially Approved**Status Date:** 08/23/2021**Correction Status:** Not Corrected |
| **Basis for Decision:**The program did no specify the procedure to ensure they obtain signed contracts from the student's sending district prior to the student starting at the program or how they will follow-up if signed contracts were not provided prior to student admission. |
| **Department Order of Corrective Action:**The program must develop and implement a plan to conduct audits of all student records to ensure student contracts have all required signatures. This plan should include the position of the staff member responsible for conducting these audits and should outline manner to document outcome of audit, the follow-up steps that will be taken if a contract does not contain the required signatures, the frequency record reviews are scheduled to occur, and system to track compliance with procedure to review student records for signed contracts. |
| **Required Elements of Progress Report(s):**For the 9/30/2021 Progress Report, the program must provide the comprehensive procedure to conduct audits of all student records to ensure student contracts have all required signatures that includes all required elements based on the Department Order of Corrective Action. For the 12/15/2021 Progress Report, the program must provide a list of current students that includes 1) the date(s) of the record review 2) whether a completed contract for the current school year with all required signatures was evident in the record3) the follow-up steps taken if the contract was missing any required elements 4) a summary of the process and any changes made to improve the approved procedure. |
| **Progress Report Due Date(s):**12/15/202102/18/2022 |

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| **Criterion & Topic:**PS 9.4 Physical Restraint | **PR Rating:**Partially Implemented |
| **Applies To:**All |
| **Department Program Review Findings:**A review of documentation indicated that the Physical Restraint Policy and Procedures included all elements of these requirements; however, staff interviews revealed that these policies are not fully implemented. Specifically, the principal or an assigned designee is not documenting weekly and monthly reviews of restraint data. |
| **Description of Corrective Action:**The Head of School will maintain records of staff attendance / participation at all trainings. |
| **Title/Role(s) of Responsible Persons:**Head of School | **Expected Date of Completion:** 10/01/2021 |
| **Evidence of Completion of the Corrective Action:**All staff will be up up to date on all required trainings and alternative plans to make up missed training opportunities. |
| **Description of Internal Monitoring Procedures:**The Head of school will conduct bi-monthly audits of staff attendance/participation at all required trainings / PD opportunities. |
| **CORRECTIVE ACTION PLAN APPROVAL SECTION** |
| **Criterion:**PS 9.4 Physical Restraint | **Corrective Action Plan Status:** Disapproved**Status Date:** 08/11/2021**Correction Status:** Not Corrected |
| **Basis for Decision:**The agency did not address the 9.4 Finding of non-compliance in their description of the corrective action plan. |
| **Department Order of Corrective Action:**The program must develop and implement a procedure for completing and documenting required weekly and monthly reviews of restraint data as required by 603 CMR 46.05 (5- 6). The weekly review log should document at a minimum: 603 CMR 46.06(5) and (6), the principal's log would need to contain the following fields, at a minimum 1) student name, 2) dates of restraint, 3) time of restraint, 4) duration of restraint, 5) individuals involved in the restraint, and 6) whether or not anyone (student or staff) was injured.This plan should include the position of the position title of the person responsible for completing the weekly and/or monthly restraint reviews, the specifice focus of each type of review based on 603 CMR 46.05 (5-6), as well as the steps to be taken if any follow-up from the review is required. |
| **Required Elements of Progress Report(s):**For the 9/30/2021 Progress Report, the program must submit the plan for completing and documenting weekly and monthly reviews of restraint data that includes the required elements listed in the Department Order of Correction. For the 12/15/2021 Progress Report, the program must provide evidence of implementation of the approved procedures for weekly and monthly reviews of restraint data. For both the weekly and monthly restraint reviews, the program must include 1) the date(s) of the review, 2) a list of staff who participated in each review, 3) a synopsis of the review and decisions made based on restraint data, if any. 4) a summary of the process and any changes made to improve the approved procedure. |
| **Progress Report Due Date(s):**12/15/202102/18/2022 |

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| **Criterion & Topic:**PS 11.3 Educational Administrator Qualifications | **PR Rating:**Not Implemented |
| **Applies To:**All |
| **Department Program Review Findings:**A review of documentation indicated that the Educational Administrator does not meet the required qualifications to serve in this position. |
| **Description of Corrective Action:**The Head of School will work with an approved / Special Education Administrator Licensed mentor who will support her (HOS) while gaining experience and working to acquire her Spec. Ed. Admin. License. |
| **Title/Role(s) of Responsible Persons:**Head of School | **Expected Date of Completion:** 10/01/2021 |
| **Evidence of Completion of the Corrective Action:**The Head of School will hold and maintain the required Special Education Admin. license. |
| **Description of Internal Monitoring Procedures:**The Head of School will continue to work with her assigned mentor and maintain the required licensure for her current position. |
| **CORRECTIVE ACTION PLAN APPROVAL SECTION** |
| **Criterion:**PS 11.3 Educational Administrator Qualifications | **Corrective Action Plan Status:** Approved**Status Date:** 08/11/2021**Correction Status:** Not Corrected |
| **Basis for Decision:** |
| **Department Order of Corrective Action:** |
| **Required Elements of Progress Report(s):**For the 9/30/2021 Progress Report, the program must submit evidence of a qualified Special Educational Administrator who has either a current special education administrator license or credentials that include all of the following: a Special Education Teacher license, or copy of an ELAR activity sheet; Evidence of a Master's Degree in Special Education or a related field; and evidence of one year of administrative experience. (The program indicated the Special Education Administrator received a Special Education Administrator license since the Draft Report was issued.) |
| **Progress Report Due Date(s):**12/15/2021 |

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| **Criterion & Topic:**PS 12.2 In-Service Training Plan and Calendar | **PR Rating:**Partially Implemented |
| **Applies To:**All |
| **Department Program Review Findings:**While the In-Service Training Plan and Calendar includes all required in-service trainings, staff interviews and a review of staff records indicated that not all staff received all mandated in-service trainings. |
| **Description of Corrective Action:**All staff in-service training schedules will be shared with staff in advance. Staff members will receive the description and overall agenda and will be required to sign in at the time of the scheduled training. Any staff member who fails to attend the training will be required to make up the training within 7 days of their return to work. Alternative training dates / materials will be created and made available. |
| **Title/Role(s) of Responsible Persons:**Head of School | **Expected Date of Completion:** 10/01/2021 |
| **Evidence of Completion of the Corrective Action:**All staff in-service records will reflect the participation of all staff members at the time of the training and/or alternative training dates. |
| **Description of Internal Monitoring Procedures:**Bi monthly review of in-service training attendance for all staff members. |
| **CORRECTIVE ACTION PLAN APPROVAL SECTION** |
| **Criterion:**PS 12.2 In-Service Training Plan and Calendar | **Corrective Action Plan Status:** Partially Approved**Status Date:** 08/23/2021**Correction Status:** NotCorrected |
| **Basis for Decision:**The corrective action plan does not specify the procedure for how documentation will be filed in staff records, who will be responsible for maintaining current training information in staff records or the specific plan for monitoring documentation of staff training. |
| **Department Order of Corrective Action:**The program must ensure all staff receive an average of 2 hours of training per month that includes all DESE mandated trainings based on the program's In-Service Training Plan and Calendar and all staff records include required documentation of training. The program must develop and implement a procedure to monitor staff training records that includes step by step procedures for completing and documenting reviews of staff training records, the position of the staff member responsible for the reviews, the follow-up plan for make-up training and/or missing training documentation, manner to document outcome and follow-up based on record review, the frequency record reviews are scheduled to occur, and system to track compliance with procedure to review staff training records. |
| **Required Elements of Progress Report(s):**For the 9/30/2021 Progress Report the program must submit the comprehensive procedure to monitor staff training records that includes all required elements of the Department Order of Corrective Action. For the 12/15/2021 Progress Report the program must submit evidence of implementation of the approved procedure to monitor staff training records that includes 1) the date(s) of the record review, 2) a list of staff who were out of compliance with required training and the plan for make-up training, 3) a list of staff whose training record was incomplete/incorrect and plan to update record. 4) a summary of the process and any changes made to improve the approved procedure. |
| **Progress Report Due Date(s):**12/15/202102/18/2022 |