**MASSACHUSETTS DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION**

Program Quality Assurance Services

**PROGRAM REVIEW**

**CORRECTIVE ACTION PLAN**

Special Education Agency: The Learning Center for the Deaf, Inc.

Program Review Onsite Year: 2021-2022

**Programs under review for the agency:**

**A - Day Program**

**B - Intensive Day Program**

**C - Residential Program**

**D - Walden School Program**

**I - TLCD Marie Phillip Walden School Day 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 05/23/2022.*

Mandatory One-Year Compliance Date: 05/23/2023

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,B,C,D,I | Partially Implemented |
| PS 11.1 | Staff Policies and Procedures Manual | A,B,C,D,I | Partially Implemented |
| PS 11.10 | Supervision of Direct Care Day and Residential Staff | A,B,C,D,I | Partially Implemented |
| PS 12.1 | New Staff Orientation and Training | A,B,C,D,I | Partially Implemented |
| PS 12.2 | In-Service Training Plan and Calendar | A,B,C,D,I | Partially Implemented |

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| **Criterion** | **Criterion Title** | **Applies To** | **PR Rating** |
| PS 15.5 | Parent Consent and Required Notification | A,B,C,D,I | Partially Implemented |

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| **PROGRAM REVIEW CORRECTIVE ACTION PLAN** |

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| **Criterion & Topic:**  PS 5.2(a) Contracts | | **PR Rating:**  Partially Implemented |
| **Applies To:**  All | | |
| **Department Program Review Findings:**  Staff interviews and a review of student records indicated that written contracts between the responsible school district and the program were not consistently signed by the placing school district. | | |
| **Description of Corrective Action:**  Staff interviews and a review of student records indicated that written contracts between the responsible school district and the program were not consistently signed by the placing school district. | | |
| **Title/Role(s) of Responsible Persons:**  Toni Ammirati - Director of Curriculum and instruction Diane Mercier - TLC Controller | | **Expected Date of Completion:** 01/16/2023 |
| **Evidence of Completion of the Corrective Action:**  TLC's accounting office will maintain a spreadsheet of contract tracking. This spreadsheet will be uploaded and shared in the progress reports  TLC will create a procedure for accounting department staff who will monitor contract signatures on a bi-monthly basis to ensure that contracts are signed. The accounting office will share their spreadsheet documentation with TLC's Educational Administrator. All contracts will be kept in the accounting office and will be submitted upon request by DESE | | |
| **Description of Internal Monitoring Procedures:**  The accounting office will maintain a spreadsheet of all contracts indicating when they were signed, any communication with the sending districts relating to a delay in signature, and any action taken to ensure that each contract is signed.  The accounting office will maintain a spreadsheet of all contracts indicating when they were signed, any communication with the sending districts relating to a delay in signature, and any action taken to ensure that each contract is signed.  The accounting office will maintain a spreadsheet of all contracts indicating when they were signed, any communication with the sending districts relating to a delay in signature, and any action taken to ensure that each contract is signed. | | |
| **CORRECTIVE ACTION PLAN APPROVAL SECTION** | | |
| **Criterion:**  PS 5.2(a) Contracts | **Corrective Action Plan Status:** Partially Approved  **Status Date:** 07/11/2022  **Correction Status:** Not Corrected | |
| **Basis for Decision:** | | |

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| The program needs to provide more information about the internal administrative review process for the newly implemented monitoring procedure. |
| **Department Order of Corrective Action:**  The program will create a new procedure for annually securing signed student contracts by describing their internal tracking and review process, having outreach to districts, designing/implementing a tracking system, and designating staff positions for each step. |
| **Required Elements of Progress Report(s):**  For the 1/16/2023 progress report, the program must submit 1) a comprehensive description of the newly implemented contract monitoring system procedure; 2) name of the staff person(s) with position title(s) who will conduct the student record contract audits; 3) a copy of the formal notification that will go out to districts as part of follow-up process; 4) name of the staff person(s) with position title(s) who will maintain communication with districts; 5) copies of all tracking documentation; and 6) name of the staff person(s) with position title(s) who will have administrative review of process. |
| **Progress Report Due Date(s):**  01/16/2023 |

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| **PROGRAM REVIEW CORRECTIVE ACTION PLAN** |

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| **Criterion & Topic:**  PS 11.1 Staff Policies and Procedures Manual | **PR Rating:**  Partially Implemented |
| **Applies To:**  All | |
| **Department Program Review Findings:**  While staff interviews indicated that staff received CORIs upon hire and every three years thereafter, a review of documentation indicated that completed CORIs upon hire were not evident for all staff. A review of documentation, staff records, and staff interviews indicated that not all staff received their annual performance evaluations according to the program's policy. | |
| **Description of Corrective Action:**  While staff interviews indicated that staff received CORIs upon hire and every three years thereafter, a review of documentation indicated that completed CORIs upon hire were not evident for all staff. A review of documentation, staff records, and staff interviews indicated that not all staff received their annual performance evaluations according to the program's policy. | |
| **Title/Role(s) of Responsible Persons:**  Toni Ammirati - DCI; Lisa Channen - HR Business Partner; Cristin Tagman - HR Manager | **Expected Date of Completion:** 12/02/2022 |
| **Evidence of Completion of the Corrective Action:**   1. As part of TLC?s progress report. TLC will submit a spreadsheet of all new employees and their date of CHRI/CORI background checks. Fingerprinting and CORIs upon hire and CORIs every three years. 2. All staff evaluation dates will be documented in a spreadsheet that will be submitted to DESE.   Human Resources staff in collaboration with the Director of Curriculum and Instruction (DCI) will create a procedure that includes how this information will be gathered (upon hire and every three years) and documented. They will try to locate all CHIR documentation from date of hire from TLC archives, and if not possible will document the most recent CHIR. They will also document CORIs for all staff at least every three years.  HR and the DCI will also create a procedure that they will communicate with all educational supervisors regarding the completion and documentation of staff evaluations. | |
| **Description of Internal Monitoring Procedures:**   1. CORI and fingerprinting documentation upon hire will be put in a staff member's permanent file. 2. All staff evaluations will be completed within 90 days of hire for new staff. All other staff members will be evaluated by/in collaboration with their direct supervisor annually or every two years, depending on their years of experience and past evaluation rating.   These evaluations will be placed in each staff member’s HR file. (Based on policy - check policy) | |

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| All supervisors will produce a spreadsheet of staff under their supervision and the date of their 90-day and/or annual evaluation | |
| **CORRECTIVE ACTION PLAN APPROVAL SECTION** | |
| **Criterion:**  PS 11.1 Staff Policies and Procedures Manual | **Corrective Action Plan Status:** Partially Approved  **Status Date:** 07/11/2022  **Correction Status:** Not Corrected |
| **Basis for Decision:**  The program is missing some specific information on the administrative review of the newly implemented documentation/tracking process. | |
| **Department Order of Corrective Action:**  The program will implement an updated process to collect, track, maintain, and review these required required elements for all staff: a CORI upon hire and every three years, CHRI fingerprinting upon hire, and performance evaluations completed per program policy. | |
| **Required Elements of Progress Report(s):**  For the 12/02/2022 progress report, the program must submit 1) the updated and newly implemented Staff Policies and Procedures process to show all required elements for collecting and maintaining current/upon hire CORI checks, CHRI checks upon hire, and staff performance evaluations per policy timeline for all employees; 2) documentation that all staff at time of progress report submission have current/upon hire CORI checks, CHRI checks upon hire and/or most recent, and performance evaluations; 3) a copy of all current Staff Rosters; 4) name(s) of the staff person(s) with position titles(s) who will be tracking, filing, and maintaining this information in program and/or staff records; and 5) name(s) pf the staff persons with position titles(s) who will be conducting administrative review of process with designated timelines. | |
| **Progress Report Due Date(s):**  12/02/2022 | |

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| **PROGRAM REVIEW CORRECTIVE ACTION PLAN** |

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| **Criterion & Topic:**  PS 11.10 Supervision of Direct Care Day and Residential Staff | | **PR Rating:**  Partially Implemented |
| **Applies To:**  All | | |
| **Department Program Review Findings:**  Staff interviews and a review of documentation indicated that documentation was not consistently evident to show that all direct care day and residential staff are receiving individual supervision on a regularly scheduled basis. | | |
| **Description of Corrective Action:**  Staff interviews and a review of documentation indicated that documentation was not consistently evident to show that all direct care day and residential staff are receiving individual supervision on a regularly scheduled basis. | | |
| **Title/Role(s) of Responsible Persons:**  Toni Ammirati - Director of Curriculum & Instruction Chris Kaftan - Director of Student Services | | **Expected Date of Completion:** 12/02/2022 |
| **Evidence of Completion of the Corrective Action:**  TLC will submit a spreadsheet of Direct Care staff, their direct supervisor, and the frequency of their supervision meetings.  The Director of Curriculum & Instruction and the Director of Student Services will create a procedure for documenting Direct Care staff supervision meetings with their Direct Supervisor including the frequency of meetings, the format (group & 1:1). Part of this procedure will include how to document meetings that occurred and how often Director’s will follow up with Supervisors to be sure they have maintained their schedule. | | |
| **Description of Internal Monitoring Procedures:**  TLC Directors will ask all supervisors to fill in a spreadsheet of the staff under their supervision and the established meeting schedule, they will follow up every three months with those supervisors under their supervision to be sure that these meeting schedules are maintained. | | |
| **CORRECTIVE ACTION PLAN APPROVAL SECTION** | | |
| **Criterion:**  PS 11.10 Supervision of Direct Care Day and Residential Staff | **Corrective Action Plan Status:** Partially Approved  **Status Date:** 07/11/2022  **Correction Status:** Not Corrected | |
| **Basis for Decision:**  The program is missing some specific information on the administrative review of the newly implemented documentation/tracking process. | | |
| **Department Order of Corrective Action:**  The program must submit a description of their updated procedure and tracking document to show that Direct Care Staff supervision is occurring for all current applicable staff and that regular administrative review is occurring. | | |
| **Required Elements of Progress Report(s):**  For the 12/02/2022 progress report, the program must submit 1) a description of the newly implemented monitoring system procedure for documenting Direct Care staff | | |

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| supervision; 2) copies of all tracking documentation for all current staff that shows name of supervisor, frequency of supervision meetings, and format of supervision meetings; 3) copies of current staff rosters; and 4) name(s) of the staff person(s) with position title(s) who will have administrative review of process with designated timelines. |
| **Progress Report Due Date(s):**  12/02/2022 |

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| **PROGRAM REVIEW CORRECTIVE ACTION PLAN** |

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| **Criterion & Topic:**  PS 12.1 New Staff Orientation and Training | | **PR Rating:**  Partially Implemented |
| **Applies To:**  All | | |
| **Department Program Review Findings:**  Staff interviews and a review of staff records indicated that documentation was not consistently evident to show that all new hire staff received all of the DESE mandated training topics within the expected timeframe before direct care duties with students. | | |
| **Description of Corrective Action:**  Staff interviews and a review of staff records indicated that documentation was not consistently evident to show that all new hire staff received all of the DESE mandated training topics within the expected timeframe before direct care duties with students. | | |
| **Title/Role(s) of Responsible Persons:**  Toni Ammirati - DCI  Lisa Channen - HR Business Partner Cristin Tagman - HR Manager | | **Expected Date of Completion:** 12/02/2022 |
| **Evidence of Completion of the Corrective Action:**  TLC will maintain documentation of new hires training through a spreadsheet that indicates the date of hire, the start date for working with students and the date of completion of DESE required trainings. This will be uploaded in our progress report.  HR in Collaboration with the Director of Curriculum & Instruction (DCI) will create a form that will be added to a staff members? personnel file that will include documentation of all DESE Required trainings (date completed). HR will be responsible for ensuring that all new staff have completed their DESE trainings before working with students. | | |
| **Description of Internal Monitoring Procedures:**  TLC will maintain documentation of new hires that will be placed in their personnel file to ensure that all DESE Required trainings have been completed prior to these staff members having direct care duties with students. | | |
| **CORRECTIVE ACTION PLAN APPROVAL SECTION** | | |
| **Criterion:**  PS 12.1 New Staff Orientation and Training | **Corrective Action Plan Status:** Partially Approved  **Status Date:** 07/11/2022  **Correction Status:** Not Corrected | |
| **Basis for Decision:**  The program is missing specific information of how DESE mandated trainings for new hires hired after the beginning of the year will be completed as well as additional information about administrative review of process. | | |
| **Department Order of Corrective Action:**  The program will create a new procedure for tracking/reviewing/ensuring that all new hire staff received all mandated DESE trainings before direct care duties with students, designating positions for staff responsible for each step, and having a plan of how trainings will be completed for mid-year hires. | | |
| **Required Elements of Progress Report(s):** | | |

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| For the 12/02/2022 progress report, the program must provide evidence that all newly hired staff who provide direct care services received all the DESE mandated new hire/orientation trainings within the required timeframes by submitting 1) a roster of all staff who were hired since 8/1/2022 that includes staff names, position title, date of hire, and start date for working with students; 2) documentation that all new staff attended all DESE required orientation trainings including training title, date, time, length, and trainer listed; 3) a description of the program's plan to ensure all trainings are completed for new staff hired after the yearly faculty in-service week; 4) the staff name(s) and position title(s) responsible for updating staff records and 5) the staff name(s) and position title(s) of staff who will have administrative review of process. |
| **Progress Report Due Date(s):**  12/02/2022 |

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| **PROGRAM REVIEW CORRECTIVE ACTION PLAN** |

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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:**  Staff interviews and a review of staff records indicated that documentation was not consistently evident to show that all staff received all of the DESE mandated annual trainings as required. | | |
| **Description of Corrective Action:**  Staff interviews and a review of staff records indicated that documentation was not consistently evident to show that all staff received all of the DESE mandated annual trainings as required. | | |
| **Title/Role(s) of Responsible Persons:**  Toni Ammirati - Director of Curriculum & Instruction Chris Kaftan- Director of Student Services | | **Expected Date of Completion:** 01/16/2023 |
| **Evidence of Completion of the Corrective Action:**   1. TLC will submit a spreadsheet with all staff, by department, with the dates that their annual DESE trainings were completed in our progress report.   The DCI and the DSS will create a procedure for staff to document the completion of their DESE trainings (e.g., a google form) for all staff hired after August 1, 2022. They will follow up with all direct supervisors who will document (Spreadsheet - staff members and trainings documented) that their staff complete the required trainings. | | |
| **Description of Internal Monitoring Procedures:**   1. TLC provides annual training for all staff on all of the DESE required trainings. These trainings are documented on a google form. 2. The google form will indicate the direct supervisor of each staff member. A spreadsheet will be shared with all supervisors who will confirm that all of their staff members have completed the required annual trainings. In this way supervisors will be able to follow up if a staff member missing a training. This spreadsheet will be reviewed in September (most trainings occur in August) and again in December. | | |
| **CORRECTIVE ACTION PLAN APPROVAL SECTION** | | |
| **Criterion:**  PS 12.2 In-Service Training Plan and Calendar | **Corrective Action Plan Status:** Partially Approved  **Status Date:** 07/11/2022  **Correction Status:** Not Corrected | |
| **Basis for Decision:**  The program is missing some specific information on the review process, a description of how missed trainings will be made up, and who will update staff records. | | |
| **Department Order of Corrective Action:**  The program will create a new procedure for annually tracking/reviewing that all staff received all mandated DESE training, designating staff positions for each step, and having a plan of how missed trainings will be made up. | | |
| **Required Elements of Progress Report(s):** | | |

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| For the 01/16/2023 progress report, the program must submit 1) a narrative to describe the new documentation procedure and review process for tracking annual mandated DESE trainings for all staff and how trainings will be made up when missed; 2) the staff position(s) and current staff name(s) of who will follow up with staff in each department, who will update staff records, and who will complete administrative review of the overall process for completion; 3) a copy of the tracking document filled out for the 2022-2023 school year with the list of all annual mandated DESE trainings completed with the date, time, and trainer listed; and 4) copy of each program's current staff roster. |
| **Progress Report Due Date(s):**  01/16/2023 |

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| **PROGRAM REVIEW CORRECTIVE ACTION PLAN** |

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| **Criterion & Topic:**  PS 15.5 Parent Consent and Required Notification | | **PR Rating:**  Partially Implemented |
| **Applies To:**  All | | |
| **Department Program Review Findings:**  A review of student records and staff interviews indicated that documentation for all required annual notifications to parents/guardians was not consistently evident. | | |
| **Description of Corrective Action:**  A review of student records and staff interviews indicated that documentation for all required annual notifications to parents/guardians was not consistently evident. | | |
| **Title/Role(s) of Responsible Persons:**  Toni Ammirati - Director of Curriculum & Instruction Chris Kaftan- Director of Student Services | | **Expected Date of Completion:** 12/02/2022 |
| **Evidence of Completion of the Corrective Action:**  As part of our progress reporting TLC will submit a spreadsheet documenting receipt of all parent consent forms which are sent out annually (fall) received through the student information system.  The Director of Curriculum and Instruction and the Director of Student Services will document the procedure by which these policies are shared with families (e.g., printed copies sent, through the student information system) annually. The department Admins (ECC, Elementary, Secondary and WS will be responsible for following up with families who have not acknowledged receipt of these policies and procedures until all families have acknowledged receipt of annual notifications. A copy of this documentation will be kept in each student’s file. | | |
| **Description of Internal Monitoring Procedures:**  TLC?s student databases will track parent receipt of emergency medical treatment, medical administration (when applicable), policies and procedures notifications (when applicable), policies and procedures manual (handbooks), Behavior Support Policy and Procedures, Physical Restraint Policy and Procedures and Bullying Prevention and Intervention Plan. A print out of this documentation will be placed in each student’s file. Department Admins will follow up with families to ensure that all have received these notifications. | | |
| **CORRECTIVE ACTION PLAN APPROVAL SECTION** | | |
| **Criterion:**  PS 15.5 Parent Consent and Required Notification | **Corrective Action Plan Status:** Partially Approved  **Status Date:** 07/11/2022  **Correction Status:** Not Corrected | |
| **Basis for Decision:**  The program is missing some specific information on administrative review of process as well as specific position titles for the person responsible for some of the steps. | | |
| **Department Order of Corrective Action:**  The program will provide copies of annual consents/notifications along with a new process to track, communicate about, and review the receipt of parent/guardian | | |

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| consents/notification acknowledgements annually. |
| **Required Elements of Progress Report(s):**  For the 12/02/2022 progress report, the program must submit 1) a copy of all required annual consents and notifications that were sent to all parents/guardians; 2) a copy of the consent/notification monitoring spreadsheet that shows the original date when documents were sent, when signed consents or acknowledgements were obtained, and dates of follow-up efforts to obtain signatures/acknowledgements (if applicable); 3) a sample e- mail of follow-up effort sent to parent/guardians; 4) a narrative of the new process including staff position(s) and current staff name(s) responsible for sending out annual consents/notifications, for tracking information on new data spreadsheet, for follow-up efforts, for submitting information into student records, and for administrative review of the process to ensure completion. |
| **Progress Report Due Date(s):**  12/02/2022 |