United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of Onsite Review: September 13-17, 2010

Date of Report: November 8, 2010

Submitted By:	Alan Harchik, Ph.D., BCBA-D Monitor
Monitoring Team:	Helen Badie, M.D., M.S. Carly Crawford, M.S., OTR/L Daphne Glindmeyer, M.D. Gary Pace, Ph.D., BCBA-D Natalie Russo, R.N., M.A. Teri Towe

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I. Background - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement (SA) covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement, the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the facilities assigned to him or her every six months, and detailing his or her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 were considered baseline reviews. Compliance reviews began in July 2010, are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of the State Supported Living Center.

In order to conduct reviews of each of the areas of the Settlement Agreement and Health Care Guidelines, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry, medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in the review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in the report for a section for which another team member had primary responsibility. For this status review, the following Monitoring Team members had primary responsibility for reviewing the following areas: Teri Towe reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, treatments and supports, and consent; Natalie Russo

reviewed nursing care; Helen Badie reviewed medical services, dental services, and pharmacy and safe medication practices; Daphne Glindmeyer reviewed psychiatry services; Gary Pace reviewed psychological care and services, and habilitation, training, education, and skill acquisition programming; Carly Crawford reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Alan Harchik reviewed serving individuals in the most integrated setting, record keeping, and quality assurance. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

The Monitor's role is to assess and report on the State and the Facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The state and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the SA.

II. Methodology - In order to assess the facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. This allowed the Monitoring Team to gain some basic knowledge about facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports, and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including

documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures being implemented.

(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. The following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, PSP team meetings, discipline meetings, incident management meetings, and shift change.

(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the facility.

III. Organization of Report – The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each facility, this section will highlight, as appropriate, areas in which the facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the SA, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility Self-Assessment:** No later than 14 calendar days prior to each visit, the facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof;
(c) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the facility has with regard to compliance with the particular section;
(d) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. It is in the State's discretion, however, to adopt a recommendation or use other mechanisms to implement and achieve compliance with the terms of the SA.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on). The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

First, the monitoring team wishes to again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at MSSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring tour. Moreover, the facility made a number of staff members available to the monitoring team in order to facilitate the many activities of the monitoring team, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations.

The facility director, Dr. William Lowry, set the tone for the week of the onsite tour. He was readily available, ensured that all requested information was obtained, and directed all of his staff to work cooperatively and openly with the monitoring team. The monitoring team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Etta Jenkins. Ms. Jenkins worked tirelessly during the week of the onsite tour (as well as during the weeks immediately proceeding and following the onsite tour) to ensure that the monitoring team members were able to obtain the information they needed to conduct this tour.

As a result, a great deal of information was obtained, as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding more than 100 individuals is included in this report. It is the hope of the monitoring team that the information and recommendations contained in this report are both credible and helpful to the facility.

Second, the monitoring team found management, clinical, and direct care professionals eager to learn and to improve upon what they did each day to support the individuals at MSSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong onsite tour. All monitoring team members had numerous opportunities to provide observations, comments, feedback, and suggestions to managers. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist MSSLC in meeting the many requirements of the Settlement Agreement.

Third, this was the first post-baseline tour of MSSLC. These tours are called compliance tours and this is a report of the compliance tour, that is, of the facility's status in complying with the requirements of the Settlement Agreement.

In addition, the Settlement Agreement requires the facility to complete a self-assessment, and to submit it to the Monitor 14 days prior to the onsite tour. In the monitoring report, the Monitor is to describe and comment upon the self-assessment steps the facility undertook to assess compliance and the results of this self-assessment. At MSSLC, the self-assessment consisted of two documents called the Plan of Improvement (POI) and Supplemental Plan of Improvement (SPOI). These were submitted to the Monitor within the required timeframes. The POI described the many actions the facility had taken, or planned to take regarding each provision of the Settlement Agreement. The SPOI described the facility's response to each of the recommendations in the baseline report. The Monitoring Panel and the parties have had a number of discussions regarding the POI and SPOI. As a result, a number of revisions and additions are going to be put in place for future POIs and SPOIs because in its current version, the documents did not provide the Monitor with sufficient detail regarding the facility's actions (e.g., number of cases reviewed, criterion used).

Fourth, a summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and an understanding of the context of the monitoring of each of these provisions can only be more fully understood with a reading of the corresponding report section in its entirety.

Restraints

- The facility had not made progress in reducing restraint incidents since the baseline monitoring visit. According to restraint data provided to the monitoring team, restraint incidents had increased by 30% each consecutive month from May 2010 through July 2010 and was at an all time high for August 2010 with 129 restraints for the month. The facility's restraint reduction committee attributed at least some of the increase in restraint incidents to recent moves within the facility, as well as to a decrease in community participation opportunities in the community. There were many meetings frequently held at the facility to address restraint incidents, including PST meetings for individuals involved in restraints, restraint reduction committee meetings, daily incident management meetings, unit meetings, and human rights committee meetings. The monitoring team was impressed by the frequent participation of staff at all levels in meetings observed the week of the monitoring visit. Many of these discussions, however, led to recommendations or corrective action. While there was considerable focus by the facility on tracking and trending restraints used for crisis intervention, there was less information and data available on the use of protective and medical restraints.

Abuse, Neglect, and Incident Management

- The number of spurious allegations at MSSLC continued to be a unique challenge for the facility. Numerous staff hours were allocated to investigations, meetings at all levels, and paperwork/data entry as a result of the high number of allegations. Staff were routinely pulled off of their regular job assignments due to allegations of abuse and neglect, leaving many individuals at the facility at risk due to inadequate staff ratios and untrained direct care staff filling in for employees reassigned. According to a log of investigations provided to the monitoring team, 997 allegations of abuse, neglect or exploitation were conducted by DFPS at the facility from 1/1/10 through 7/27/10. Of these 997 allegations, 69 (7%) were confirmed by DFPS. This included 23 confirmed allegations of physical abuse, 3 confirmed allegations of sexual abuse, 40 confirmed allegations of neglect, 12 confirmed allegations of verbal or emotional abuse, and one confirmed allegation of exploitation. This was an alarming number of confirmed allegations of abuse and neglect. The facility needs to immediately examine facility trends and develop a plan of correction to address any trends identified in confirmed cases. One concern of the monitoring team regarding incidents at the facility was the lack of documented follow-up to ensure corrective actions were taken to prevent additional incidents. There were a total of 3,463 injuries reported during the first three quarters of FY10. This was an increase of 28 injuries when compared with the first three quarters of FY09. The facility trended those injuries by home and by shift, but not by injury type or cause. Without identifying the cause or type of injuries occurring most often, this information was not adequate

for developing a plan of correction to reduce the number of injuries. Video surveillance cameras had been installed in common areas throughout the facility since the baseline monitoring visit. A review of incident investigations indicated evidence from the surveillance cameras was being used in investigations. It was reported in interviews during the monitoring visit that this evidence was beneficial in confirming abuse and neglect in cases where evidence might not otherwise have been available to support the allegations.

Quality Assurance

- MSSLC was not in compliance with this provision. Little activity had occurred since the baseline monitoring tour. A new director of quality assurance had been appointed and there were plans to revise the overall QA program at the facility and across the state. This included the creation of a Quality Assurance and Improvement Committee (to replace the PIC) and the contracting with an outside vendor to develop a QA program at each facility. At the time of this monitoring tour, an adequate, comprehensive quality enhancement plan did not exist. Facility-wide data were not directed to the QA department. Regular reports were not completed by the QA department for use by senior management. Even so, a number of QA-related activities continued to occur at MSSLC, including the observation and monitoring of various areas by department staff across the facility. These data were brought to PET meetings (there were three different PETs at MSSLC) and then summarized for the PIC. Other data were collected by the QA staff. Some of the data were graphed. Trend analysis data were collected at MSSLC (as was done at all facilities), however, at MSSLC the data were graphed and summarized in a manner that was useful to facility management. The monitoring team's checklist tools were being sampled and tried out by the QE staff and many other managers around the facility. The self-advocacy group had been assigned a new facilitator, the new facility rights protection officer.

Integrated Protections, Services, Treatment, and Support

- The DADS policy for this section had been revised and approved 7/10/10. Most of the forms and instructions relative to PSP development had been revised either just days prior to the monitoring visit or in the weeks following the visit. Most of the PSPs reviewed for compliance with this provision were dated prior to the approved policy revision and subsequent changes in PSP format, therefore, the team was unable to assess implementation of the new policies and procedures for compliance with this provision. QMRPs were scheduled to attend training on developing person centered plans. The facility needs to ensure that the QMRPs have support from all team members and facility administrators to change the current process used to develop PSPs and that all team members understand the underlying philosophy behind the changes. The monitoring team met with the QMRP Director and some of the QMRP Supervisors during the monitoring visit. They were anticipating changes to the process of PSP development following upcoming training. The QMRP department had already implemented some changes and were trying to focus on a process that would encourage better person centered planning and bring PSP development in line with requirements of the Settlement Agreement. A

sample of 21 Personal Support Plans (PSPs) was reviewed. Plans were essentially identical for each individual. All PSPs reviewed included two basic outcomes that were not based on the individual's stated preferences. Action steps were also similar and provided no specific information to offer guidance in carrying out the plan and providing necessary supports.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- State policy was not developed or implemented at the time of the onsite tour to address this provision of the Settlement Agreement. The facility had identified the medical director as the lead manager for this provision of the Settlement Agreement, and some activity had occurred regarding this provision item since the baseline tour. Clinicians across the facility were becoming familiar with this provision. A number of examples of ways in which MSSLC was working towards a greater integration of clinical services, as well as examples of areas in which integration was not occurring, are presented below. Across the facility, there was great desire for coordinated clinical treatment, and to have that treatment contain more than just the minimum generally accepted professional standards of care as set forth in this provision.

At-Risk Individuals

- State policy had been developed to address assessing risks for individuals. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. The rating forms allowed individuals who were at risk to be rated low if plans were in place to address specific risk. This practice continued to be a concern to the monitoring team because it did not alert staff that individuals at risk needed to be monitored more frequently for signs and symptoms of risk. The other concern of the monitoring team regarding risk ratings was that plans addressing risk were often not sufficient or were not monitored adequately placing the individual at risk, even with a plan in place. Risk levels often conflicted with information included in the PSP by specific disciplines. Comprehensive risk reviews that considered and analyzed influencing factors contributing to each risk area needed to be completed. All staff needed to be aware of and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. The monitoring team recommends that the facility clarify the purpose and process of the identification of at-risk individuals. MSSLC's Health Status Team (HST) Coordinator was scheduling and conducting meetings according to the policy. An HST meeting was held during the monitoring team's onsite review. The HST was observed and documented to be an interdisciplinary review of risk factors. There was great discussion among team members regarding supports and services needed to address risk factors for individuals. Each discipline contributed to the discussion and appeared to know the individuals being reviewed well. Nevertheless, it was noted that accurate risk levels were not being assigned through this process.

Psychiatric Care and Services

- Although psychiatry consultations were occurring, MSSLC was found to be in noncompliance with all but one of the items in this provision of the Settlement Agreement. The facility did have physicians, provided by a locum tenens corporation, who were qualified by virtue of their board eligibility/certification status to provide services at MSSLC. The facility has reportedly had a history of difficulty recruiting and retaining physicians. As such, the primary goal must be to recruit and retain psychiatrists such that the psychiatric program can be expanded to provide clinical services and integrated with other disciplines to meet the requirements of the agreement. The current psychiatric physicians had integrated themselves well with the primary care physicians. There were beginnings of integration with psychology staff, however, this was apparently physician-specific to one psychiatric provider and, unfortunately, this was the provider who was departing. Given the facility's history of reliance on locum tenens physicians, it was recognized that they may experience difficulty with recruitment of a full-time psychiatrist. The medical leadership should consider the development of a recruitment/retention plan for psychiatry, and if this is not successful, should consider the development of a training document that allows new psychiatrists to become quickly familiar with the facility and practice parameters within the facility that comport with the Settlement Agreement so that they can "hit the ground running." While psychiatry was interacting with psychology on some levels, there were marked deficits in the interaction. It was apparent that some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., informed consent and risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of target symptoms, data collection, collaboration regarding case formulation). The staff from both disciplines were aware of the challenges and the need for increased structure and integration, however, they were also aware of the manpower shortage and history of high turnover in psychiatry, which did not lend itself to close collaboration. What was most striking during the tour, was that staff overall were caring and invested in the treatment of the individual and had the desire to see the individual benefit from treatment. Even so, while they were able to verbalize the need for specific treatment interventions and to back these recommendations with clinical evidence, they were stymied when it came to requesting approval for the plans or implementing them.

Psychological Care and Services

- Although only one of the items in this provision was found to be in substantial compliance, there was progress in several items. These areas of improvement since the baseline review were that (a) several psychologists were enrolled in coursework to become certified in applied behavior analysis (BCBA), several other staff were approved (or were in process of seeking approval) to sit for the BCBA national exam, and a consulting BCBA was hired to supervise and offer technical support to staff in the BCBA program; (b) improvements were evident in data collection, and (c) progress had been made toward ensuring that psychological therapies were evidence-based, and goal directed with measurable objectives. There were also areas that the monitoring team believed

required immediate attention. Those areas included that (a) a plan needed to be developed to ensure that those psychologists not enrolled in BCBA coursework, or eligible to sit for the exam, received the training and experience necessary to write effective positive behavior support plans; (b) the new data system needed to be expanded to all homes and day sites, the types of data collected needed to be expanded, and interobserver agreement needed to be consistently assessed and tracked; (c) many components of a functional peer review system existed at MSSLC, however, peer review needed to be expanded to include an opportunity for staff psychologists to present and discuss individual treatment plans beyond those requiring administrative approval, and (d) the facility needed to clarify what behavior procedures can and cannot be used at MSSLC.

Medical Care

- The facility was still in the very beginning stages of addressing this provision of the Settlement Agreement. Medical policy had been issued from state office, but the medical director reported that state office had directed the facility to make no changes until further guidance was provided. The medical staff was comprised of six primary care physicians, a medical director, and three psychiatrists. Five of the six primary care physicians were temporary locum tenens physicians as were all three of the psychiatrists. The medical director did not carry a caseload. It was reported by the medical director that physicians tended to rotate every three months. Four of the six primary care physicians started in July 2010. The PCPs shared a collegial relationship. They participated in daily staff meetings and engaged in weekly working lunches. It was quite evident that they wanted to serve the individuals in the best manner possible. During the week of the onsite review, they attended numerous supplemental and emergency meetings in an effort to overcome what they perceived as barriers to their ability to practice in the best interests of the individuals. It was apparent that training related to issues of rights and protection was not adequately provided. This was most evident in the area of restrictions and differentiating between behavioral and medical restraints. Primary care physicians conducted clinic daily starting around 8:30 am. Each unit had a clinic where individuals were taken to see their physician. A calendar was maintained in each dorm that listed who needed to be seen and the reason for the MD evaluation. Individuals requiring acute care were transferred to local hospitals for evaluation and/or admission. The facility maintained a hospital liaison program through nursing services. There was no progress made in implementing a medical quality program. Death reviews were consistently completed at the facility, but these reviews did not include an external reviewer. All deaths reviewed for the year 2010 were attributed to either pneumonia or malignancy. This pattern, as well as the actual mortality review process, requires further assessment by the facility.

Nursing Care

- At MSSLC, the nursing staff members were an experienced and talented group of nurses. The facility should be commended for its recent reorganization of all individuals' records and significant improvements in record-

keeping practices. Records were organized, and nurses' notes were usually in the SOAP (Subjective and Objective (data), Analysis, and Plan) format. It was an infrequent occurrence to find a record note that was illegible, improperly signed and dated, and/or not designated as a late and/or erroneous entry, when or if needed. There was evidence across the 30 individuals reviewed that the individuals' RN or campus RN was usually notified in a timely manner of significant changes in their health status and needs and/or when it became apparent to the LVN that the individual may have needed to be seen in "sick-call" by his or her physician. In practice, however, 24 of the 30 records reviewed showed that nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions to achieve desired health outcomes. Thus, the conclusion (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This was a serious problem because the HMPs and the selection of interventions to achieve outcomes were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. All 30 individuals reviewed had some of their health needs and risks referenced in Health Management Plans (HMP) and Nursing Care Plans (NCPs). These plans were developed by their RN case manager in response to identified health needs, identified risks, and/or significant changes in health status. The forms, processes, and plans in place at the time of the review, however, had problems and were in need of complete review and revision in order to promote progress toward the achievement of this provision of the Settlement Agreement. MSSLC had a health risk assessment rating tool and held a regular health status team meetings. As noted in the baseline monitoring report, and as had continued, these processes had problems that resulted in what appeared to be incorrect ratings of risk for many individuals in important areas of risk and/or failure to increase level of risk in a timely manner such that the likelihood of harm and negative health outcomes was minimized. The administration of medication and the management of the medication administration system at MSSLC had improved since the baseline monitoring tour. As indicated in more detail below, additional work still needed to be in the areas of proper completion of the MARs, management of the medications by the nurses, and in the oversight of medication errors.

<u>Pharmacy Services and Safe Medication Practices</u>

- Progress had been made with regards to verification of physician orders. Drug regimen reviews were consistently completed in all records reviewed. The quality of the reviews and value to the physicians were significant problems that require corrective actions. The MOSES and DISCUS scales were completed, but did not appear to register with the medical staff as valuable, based on the lack of completion of the tools. Much work is needed in the area of medication errors. The starting point must be acquiring valid and reliable data. The extent of medication errors at the time of the review was unknown. The facility had a procedure related to adverse drug reactions at the time of the visit, yet none were reported. Such systems provide useful data particularly in facilities where high risk drugs must be used.

Physical and Nutritional Management

- The process used to establish health risks was inconsistent across the HST and NMT. Different screening tools were used and there was little to no integration across these two systems. This system, as used statewide, was ineffective and did little to heighten the awareness of potential harm to those individuals with complex and serious health risk concerns or to enhance the intensity and frequency of intervention, review, and monitoring. It was understood by the monitoring team that a new system to assess health risk had been, or was soon to be, developed. The interaction, discussion, and analysis noted during observation of a case on 9/16/10 showed promise of improved integration and problem solving. There was participation by all team members, including the direct support staff. The effectiveness of this new process will be further evaluated in subsequent reviews. Unless an individual participated in direct therapy, there was no consistent interval of review of other supports for those individuals who presented with PNM health risk indicators by professional staff. In the case that an individual participated in direct therapy, a monthly progress note was written, but functional and measurable goals were not identified in all cases. There was no system of monitoring of PNMP effectiveness for those at highest risk. There was no mechanism to track data for system analysis in order to focus training and coaching. The NMT did not utilize PNMP monitoring information in their reviews. The NMT did not specifically review aggregated findings across homes for trend analysis to drive system change and training. There was no system in place to conduct routine review in order to determine if interventions had a positive outcome on an individual's health status. There was also no review of the overall incidence of health concerns, such as aspiration pneumonia, use of bowel management aides, weight loss/gain, falls, fractures, and so forth over time to address system outcomes as a result of interventions and supports. Based on observations of individuals across a variety of homes, particularly during meals, there continued to be concerns for staff implementation of interventions and recommendations outlined in the PNMP.

Physical and Occupational Therapy

- The previous department director had taken a position as the Director of Quality Assurance and an Interim Habilitation Therapies Director, Gary Sandler, MOT, OTR/L was temporarily assigned to this role from another SSLC. His last day at MSSLC was 9/16/10 during the week of this onsite review. Sandra Opersteny, PT, MEd had been appointed as the subsequent Interim Director. There had been a recent collaboration with a vendor who held RESNA certification as an Assistive Technology Professional and was an excellent step in the improvement of assistive technology at the facility, particularly related to wheelchair seating and mobility. This had been met with significant resistance by the clinicians, however and, the success of this arrangement stood in the balance. The reorganization of the PNMP Coordinators appeared to have been a positive step. The current system of PNMP monitoring was generally limited to availability and condition, rather than function and fit. Tracking and documentation of monitoring were not yet in place. PNMPCs, however, were more consistently providing staff

training when issues and concerns were identified, both on the spot and with inservices. This was the primary area of improvement noted related to provision P. Assessment format, detail, and clinical reasoning varied greatly from report to report. Most of these were not comprehensive in that they contained some critical information regarding health risk indicators and, generally, only a list of medical diagnoses was offered with no real discussion of the individual' s medical history. PSP Addendums were generally not conducted to justify the addition of therapy services. Treatment plans were outlined in an acute care assessment, but were not included as training objectives in the PSP. These interventions were treated more like hospital or outpatient treatments rather than as an integrated aspect of the annual plan for an individual living in an SSLC.

Dental Services

- Assessing the facility's compliance with this provision was difficult based on the data submitted. Document requests for lists of individuals in some instances were not met. Instead, the monitoring team was provided a coded spreadsheet that contained numbers for procedures and not a list of individuals. A second spreadsheet was provided with a list of individuals and appointment dates. The data did not verify that the appointment date met the timeframe for the annual appointment. In fact, the spreadsheet did not specify that the appointment date listed was the annual appointment date. Record reviews indicated the individuals received a variety of services in the dental clinic and without the use of restraints. Over 350 appointments were missed. This represented a tremendous amount of wasted opportunities considering that provision of oral hygiene in the homes appeared problematic. Many individuals were returning to dental clinic on a monthly basis to have the hygienist perform tooth brushing and cleaning. Informal desensitization plans and other techniques were documented in the spreadsheet provided. This appeared to have resulted in some success.

Communication

- Speech staff were not able to provide sufficient and adequate communication supports and services based on individual needs due to inadequate staffing. There was evidence that only one individual received direct communication intervention and there were only six others who were recommended for some type of AAC system beyond the communication dictionary provided. It appeared that some who were to use these devices did not have consistent access to them. While much work had been done to retrieve some devices that had previously been issued and were not effective or appropriate, there were still many who would likely benefit from the correct communication system with the right supports. While assessments generally contained some basic elements, there was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish goals and objectives for communication supports and interventions. It was also often not clear as to how effective the current methods used by each individual were within their daily routine. Most staff were observed to be communicative and interactive with individuals during a variety of activities, including day programming activities and, in some cases, mealtimes, however, there was little interaction noted

during the in-between times, such as before meals when most individuals were observed to be sitting around and waiting. Much of the interaction observed was utilitarian to a specific task with little other interactions that were meaningful. Devices noted in the day programs were not always placed where the individual had ready access to the device and, as a result, spontaneous opportunities to use the system and seek a response from others or reinforcement of communication efforts were limited.

Habilitation, Training, Education, and Skill Acquisition Programs

- This provision incorporates a wide variety of aspects of programming including skill acquisition, engagement in activities, and staff training. To assess compliance with this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. Although no provisions of the Settlement Agreement were found to be in substantial compliance, the facility was making good progress in several areas including an improvement of the procedures used to teach new skills, the addition of graphing of specific program objectives (SPOs), and new treatment integrity and engagement tools. Many of these improvements were too new to be fully evaluated by the monitoring team and will be reviewed in future tours. Progress was also noted in the public school educational services provided.

Most Integrated Setting Practices

- MSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. Overall, MSSLC continued to place many individuals in the community. Approximately 100 individuals had been placed in the past year and facility staff were proud of this accomplishment. Moreover, individuals across the campus spoke about wanting to transition to the community. MSSLC maintained an active admissions and placement department. Given the number of transitions, not all work met deadlines (e.g., post move monitoring visits) and not all work was done as thoroughly as it should have been (e.g. CLDP contents). Nevertheless, the staff were knowledgeable and committed to making successful placements and improving their processes. Since the baseline tour, some activities had been directed towards reviewing the CLDPs of individuals who had transitioned over the past six months as well as improving the list of essential and nonessential supports in each CLDP. More work was being done on these areas, but little improvement was observed. Other aspects of this provision were not yet in place in a manner to meet the requirements of this provision, including determining the supports, needs, and preferences of individuals and the characteristics of settings that would support their successful transition and ongoing lifestyle in the most integrated setting appropriate to their needs (i.e., part of the PSP process), determining and addressing barriers and obstacles to placement, and providing individuals with appropriate exposure to community options (e.g., tours). Post move monitoring was occurring. It was being done by a variety of facility and non-facility staff. Variability in the thoroughness of completion of post move monitoring was found. There continued to need to

be more detailed descriptions of essential and nonessential supports so that they could be observed and so that the post move monitors would know what was required to indicate evidence of the presence of the support. Some individuals were discharged according to provision T4 who did not appear to meet any of the criteria. This will need to be reviewed by the facility and corrected if need be.

Consent

- The facility had not begun to formalize a process for identifying individuals in need of LARs or identifying resources for finding guardians. The facility provided the monitoring team with a list of 14 individuals in need of an LAR. A review of PSPs indicated that this was not a complete list of individuals at the facility who needed an LAR.

Recordkeeping and General Plan Implementation

- MSSLC made great progress towards meeting this provision. The new policy and record keeping practices were implemented across the facility. The unified record for every individual was created, including a reformatted active record and a brand new individual notebook. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. A master record existed and contained the required typical documents. The Director of Client Records and the two Unified Record Coordinators were committed to having an organized, user-friendly record keeping system. They were knowledgeable about the records, had many years of experience at MSSLC, and were interested in improving the records as implementation of this new system moved forward. A further indication of progress in this area was that audits of the active records by the recordkeeping department had commenced in July 2010. Through the time of the onsite monitoring tour, 26 audits had been completed. Useful information was obtained during these audits. A system, however, was needed to ensure that corrections were made to the records based on the audits. Further, an additional audit tool was needed to ensure that all contents of all components of the record were audited. MSSLC should ensure that record keeping is tied into the facility's quality assurance program and that quality assurance activities occur related to record keeping. Moreover, it will be important for MSSLC to obtain feedback and suggestions from those who use the records regularly in order to make relevant and useful changes to the record keeping system. This was beginning to occur at MSSLC: a task force had been formed to look into the usage of the individual notebooks given the many challenges that were occurring at the facility in the implementation of that aspect of the new unified record system.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of MSSLC. The monitoring team hopes that the comments throughout this report are useful to the facility as it works towards meeting the many requirements of the Settlement Agreement.

The monitoring team continues to look forward to continuing to work with DADS, DOJ, and MSSLC.
Thank you for the opportunity to present this report.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Use of Restraint Policy #001, dated 8/31/09 o DADS Administration of Chemical Restraint Consult Form o DADS Emergency Restrictive Practice HRC Review Form o DADS Restraint Checklist Form, numbered 06032010R o DADS Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint o DADS Restraint Documentation Guidelines for State Supported Living Centers, November 2008 o List of all restraints used for crisis intervention in August 2010 o List of Dental Sedation (chemical restraint) and Desensitization Plan Information o List of all individuals with safety plans o Restraint documentation for Individual #422 6/25/10-8/20/10 o Documentation for three incidents of restraint for Individual #99 o Restraint Checklists for Individual #312 and Individual #241 o Restraint Debriefing forms for Individual #355, Individual #426, Individual #169, Individual #312, Individual #241, and Individual #211 o Dates for the above four sets of documents • Individual #99 - 8/16/10 • Individual #312 - 8/16/10 • Individual #241 - 8/15/10 • Individual #355 - 8/13/10 • Individual #426 - 8/13/10 • Individual #169 - 8/15/10 • Individual #211 - 8/16/10 • Individual #422 - 6/23/10, 6/25/10, 6/27/20, 6/29/10 (x3), 7/2/10, 7/4/10, 7/6/10, 7/9/10, 7/10/10, 7/13/10, 7/16/10 (x4),7/19/10, 7/21/10 (x2), 7/26/10 (x2), 7/28/10, 7/298/4/10 o MSSLC Restraint Trend Analysis Report FY10 o PSP, PSP Addendums, Structural and Functional Assessment, BSP, Safety Plan, and HRC approval form for Individual #422 o Minutes of human rights committee meetings, 6/10-8/10 Interviews and Meetings Held: o Interviews with various direct support professionals in homes and day programs o Charles Bratcher, Quality Services Management

	o Charlotte Kimmel, Director of Psychology o Dolores Erfe, M.D., Medical Director <u>Observations Conducted</u>: o Observations at all residences o Observations at the onsite workshop o Shamrock Unit Meeting 9/14/10 o Daily Incident Management Meeting 9/14/10 o Daily Incident Management Meeting 9/15/10 o PSPA for Individual #300 9/15/10 o Human Rights Committee meeting 9/14/10 o Incident Management Meetings 8/17/10 and 8/18/10
	Facility Self-Assessment: The facility's self-assessment, its POI, for section C indicated that all items were in noncompliance. The POI noted, for most sections of this provision, that the facility will continue to review restraints and retrain staff as needed. The monitoring team agrees with the facility's determination of noncompliance for section C. This section was rated based on review of restraint incidents, interviews, and observations. The monitoring team found that while most staff had received training in the use of restraint and documenting restraint, staff were not implementing procedures included in training. Prior to retraining staff, the facility should review training methods to determine if changes are needed in current training methods. There were systems in place for the monitoring and review of restraint incidents, but these did not appear to be effective as evidenced by findings throughout section C. The facility will also need to take a look at the restraint review process for determining compliance with this provision. In order to gain substantial compliance with this provision, it will be essential for all staff at the facility to adopt the philosophy that restraints will be used as a last resort measure and that staff must be provided with the tools and knowledge necessary to make this a realistic outcome.
	Summary of Monitor's Assessment: The facility had not made progress in reducing restraint incidents since the baseline monitoring visit. According to restraint data provided to the monitoring team, restraint incidents had increased by 30% each consecutive month from May 2010 through July 2010 and was at an all time high for August 2010 with 129 restraints for the month. There was a 23% increase in the use of restraints in August 2010 over the previous month. Programmatic restraints had increased 56% in July and over 50% in June. Restraints had increased 67% in home S5B, accounting for the greatest number of restraints. The facility's restraint reduction committee attributed at least some of the increase in restraint incidents to recent moves within the facility. It was not evident that teams had met and planned for transition with these individuals. A group of individuals had been moved from one home into a new home with little evidence of their participation or even agreement to the move. It was noted during a tour of the new home

	that many of the individual's rooms were barren; they did not have pictures on the walls, bedspreads, or other things to make the new room feel like their personal space. Involving the individuals in the move and helping them to establish their personal space before the move may have reduced some of the anxiety and anger associated with the move. Another cause identified by the restraint reduction committee for the increase in restraint incidents was a decrease in community participation opportunities in the community. This decrease was attributed to lack of sufficient staff and transportation available for community outings. It was noted that there had been a large number of new staff employed that were not yet comfortable supporting individuals in the community. The committee stated that new transportation would soon be available at the facility and the facility continues to focus on training new staff to adequately support individuals in the community. There were many meetings frequently held at the facility to address restraint incidents, including PST meetings for individuals involved in restraints, restraint reduction committee meetings, daily incident management meetings, unit meetings, and human rights committee meetings. It was observed by the monitoring team that most of these meetings were attended by an appropriate interdisciplinary team and good discussion took place among meeting participants. The monitoring team was impressed by the frequent participation of staff at all levels in meetings observed the week of the monitoring visit. It was noted, however, that discussions led to very few recommendations and the overall consensus of the participants was that things could not be changed at the facility. Therefore, very few meetings resulted in corrective action. As evidenced in comments throughout section C of this report, restraint was rarely used as a last resort measure. PBSPs did not include effective support strategies for staff to implement in a behavioral crisis to prevent the use of restraints. Teams need to review behavioral support plans and implement changes when strategies are not effective. Individual #422 had the highest number of restraint incidents at the facility, including 24 in the month of August 2010 alone. Her PBSP was dated February 2010 and included very few strategies other than verbal prompts to stop the behavior. While there was considerable focus by the facility on tracking and trending restraints used for crisis intervention, there was less information and data available on the use of protective and medical restraints. The facility was in the beginning stages of addressing reduction of medical restraints. Information on restraints used for medical appointments was not included in quarterly trend analysis reports.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if	The state policy prohibited the use of prone restraints and mandated that restraints only be used if the individual posed a serious risk of harm to himself, herself or others, after a graduated range of less restrictive measure had been exhausted, and be terminated as quickly as possible and as soon as the individual was calm and no longer a danger to self or others. The policy further specified what types of restraints were allowable at the facility. These policies were in line with the requirements of this provision.	Noncompliance

#	Provision	Assessment of Status	Compliance
	the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The monitoring team, however, was unable to find the facility in substantial compliance with this provision item based upon documentation provided during the review and described below. It was found that restraints not approved by state policy had been used at the facility. In DFPS investigation #36702729, abuse was confirmed on two staff members for the use of unauthorized restraints, one used a gag (unauthorized mechanical restraint) and the second a chokehold (unauthorized restraint) on Individual #462. According to the investigator, the restraint documentation completed on this incident by staff indicated that this was an appropriate restraint. Thirty-seven restraint reports across eight individuals were reviewed. A review of 26 restraint checklists for Individual #422 from 6/25/10 through 7/27/10 indicated that restraints were not used after a graduated range of less restrictive measures had been exhausted. Nineteen (73%) of the restraint checklists indicated that verbal prompts were the only intervention attempted to avoid restraint, four (15%) indicated that verbal prompts were used with redirection attempts, one indicated that PMAB protective skills were attempted, and one indicated that restraint was the only technique attempted. A review of three restraint checklists for Individual #99 indicated that verbal prompts were the only interventions attempted to avoid restraints in all three incidents. One bear hug and two horizontal restraints were initiated when verbal prompts failed to stop the targeted behavior. According to the state policy, the maximum time in restraint for crisis intervention prior to attempting release is 30 minutes. In the sample of restraints reviewed for Individual #422, the following restraints were not in compliance with this policy: • Restraint on 6/25/10 - first documented attempt to release her occurred after 38 minutes • Restraint on 7/2/10 -first documented attempt to release her occurred after 60 minutes. • Restraint on 7/26/10 -first documented attempt to release her occurred after 36 minutes. On the Restraint Debriefing, Review, and Face-to-Face Assessment for Crisis Intervention form completed for the restraint incident of Individual #422 on 6/25/10, there was a note stating, "Per restraint free Friday instructions," the unit director, campus supervisor, home manager and psychology were requested to come to the site of the restraint to go through the debriefing process. The debriefing form indicated "no problems" with the	

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		restraint. A review of the restraint checklist, however, indicated: • The incident was documented on the wrong form. DADS revised the restraint checklist on 6/3/10. The facility was not using the latest revision of the form. • The checklist indicated that the only intervention attempted to avoid restraint was the verbal prompt: "I said Ms _____, stop." • The checklist did not indicate that a less restrictive hold was attempted prior to placing the individual in a horizontal restraint hold. • The restraint started at 10:30 am. The restraint monitor documented in the action/release section that the individual was quiet/calm at 10:45 am and at 11:00 am, but no release was attempted at either time. • Duration of the restraint was 38 minutes with no attempts to release the individual. This violated the policy requiring an attempt to release the individual within 30 minutes. It was a concern to the monitoring team that the restraint and documentation of the restraint violated several provisions of the state policy, yet, administrative staff trained in restraint application and documentation did not identify any problems after witnessing the restraint and reviewing documentation. On 7/2/10, a chemical restraint was administered to Individual #422 after she was released from a one hour horizontal hold. The documentation of the restraint indicated that the individual was calm when the chemical restraint was administered and there was no immediate risk of harm to herself or others. It was not clear why the chemical restraint was not administered earlier if the individual remained agitated throughout the one hour physical restraint. The restraint form did not indicate that the restraint was monitored by the nurse for the next two hours as required by state policy with chemical restraints. The facility needs to ensure that restraints are used only after a series of less restrictive measures are attempted and that the individual is released as soon as he/she is no longer a risk to herself/himself or others. All restraints should be monitored according to guidelines included in the state policies.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The facility policy mandated that restraints be terminated as quickly as possible and as soon as the individual was calm and no longer a danger to self or others. Most restraint checklist indicated that the individual was released from restraint when calm, though two examples reviewed indicated that the individual was not released when calm. The monitoring team was unable to find the facility in substantial compliance with this provision item from documentation provided during the review.	Noncompliance

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		On a Restraint Checklist dated 6/25/10 for individual #422, the restraint monitor indicated that the individual was quiet and calm when observed 15 minutes after the start of the restraint (horizontal hold), but no attempt to release the hold was documented. Thirty minutes after the start of the restraint, the monitor made the next observation entry on the form, again indicating that the individual was still quiet and calm, however, no attempt was documented to release the individual. The duration of the restraint was 38 minutes. Another restraint incident for Individual #422 on 7/2/10 indicated that the individual was restrained in a horizontal hold for one hour. Documentation did not support that a one hour restraint was warranted. The restraint monitor completed the action/release code section indicating that the individual was angry and pulling at the restraint during the first minute of restraint, but no further behavior during restraint was documented. The form indicated that the individual was calm when released one hour later, but then the nurse administered a chemical restraint (Ativan). According to the Restraint Debriefing form, the chemical restraint was administered to help her relax and remain calm. There was no indication that she was a danger to herself or others at this point. There was no evidence that the chemical restraint was documented. It was not evident that individuals were always released from restraints when they were no longer a danger to themselves or others.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and	The facility had adopted the state policy governing the use of restraints. The policy was in compliance with the requirements of this provision. Training transcripts were reviewed for the last three employees completing training at MSSLC and 13 experienced long-term direct care staff. The three new employees had completed Use of Restraint and PMAB training prior to working with individuals as required by state policy. Two of the long-term employees had not completed PMAB training within 12 months as required by state policy. Both trainings were competency based with competency demonstration testing required. In many cases, restraints were not implemented or monitored according to methods included in required training. See section C1 for specific details regarding documentation. The facility needs to ensure that correct forms are available for use by all staff and staff are trained to complete documentation as required by state policy. The facility was rated as being in noncompliance with this provision item.	Noncompliance

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	redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.		
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	The facility was not collecting and analyzing data in regards to medical restraints. The facility was, however, tracking dental restraints. The incidence of dental restraints was low at the facility and the dental staff made great efforts at implementing desensitization strategies for individuals at the facility. According to a list provided to the monitoring team, there were only eight individuals approved for dental restraints and all eight had a desensitization plan in place. The monitoring team commends the facility staff for their efforts to minimize dental restraints. For example: • Individual #481's PSP stated that she had "head and body movement sometimes sudden and forceful during dental procedures." It noted that during dental procedures her head was cradled against an arm and her hands are held to control her movement to reduce the risk of injury. Her desensitization plan was to take frequent breaks during dental procedures for talking and moving. • At the PSP annual meeting observed for Individual #378, the PST discussed the need for dental restraints and determined that restraint was no longer necessary and would be removed as a restriction. They made recommendations to keep appointments short and see the dentist monthly to maintain desensitization to dental procedures. PSTs at the facility had identified individuals who were at risk for injury if restrained. Staff in the homes knew which individuals were on this list and were aware of the risks for those individuals. As noted throughout section C of this report, however, there was no evidence to support that restraints were limited to crisis intervention or medical needs. There was little information available on the use of medical restraints. Therefore, the monitoring team was unable to verify that PSPs for individuals included treatments or strategies to minimize or eliminate the need for restraint when medical restraints were being used. Thus, the facility was rated as being in noncompliance with this provision item. Some examples of documentation that did not support that restraint was only used if the individual was at risk of harming himself, herself, or others are presented below: • In the restraint incident documentation involving Individual #241 on 8/15/10, staff stated that the individual was running and cussing. Staff told him to stop and go home and grabbed the back of his shirt. The individual than started to	Noncompliance

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		elbow the staff member and was placed in a basket hold. If staff had not grabbed the individual by his shirt, he may not have become aggressive towards the staff person. • Restraint documentation for Individual #426 on 8/13/10 indicated that restraint was used because "it was likely that the individual would have hit the staff if a restraint was not initiated." Documentation did not indicate that staff attempted any other type of intervention prior to restraint. • Restraint documentation for Individual #422 on 8/4/10 indicated Ativan and Haldol were administered following a horizontal restraint. Documentation did not indicate what behaviors precipitated the use of restraint. • Restraint documentation for Individual #422 on 7/16/10 indicated that the individual was restrained for pulling on another person's shirt after a verbal prompt was unsuccessful.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional	It was not evident that restraints were always monitored as required by state policy. Some examples are provided below. • Individual #99 was restrained at 6:00 am 9/13/10, then again at 6:20 am, and a third time at 6:30 am. The final restraint ended at 7:00 am. The nurse did not document an attempt to monitor his vital signs and mental status until 8:40 am. • On 8/6/10, Individual #398 was given Ativan 2 mg and Thorazine 50 mg IM for behavior intervention. When this was not effective, she received the same dose of medications 30 minutes later. Her vital signs and mental status were not monitored by a nurse every 15 minutes for two hours as required in state policy. The nurse documented her vital signs and mental status one time, one hour and 15 minutes after she received the first injection. • Individual #241 was restrained on 8/15/10. The nurse documented his vital signs and mental status, but did not give the time documented. • Individual #422 was restrained on 7/2/10 in a horizontal hold for one hour. Documentation indicated that the nurse first evaluated her vital signs and mental status 31 minutes into the restraint. A second evaluation by the nurse was not completed until 42 minutes later. The facility needs to ensure that all restraints are monitored as required by state policy and provisions of the Settlement Agreement. Monitoring and post restraint review should be consistently documented on the correct forms.	Noncompliance

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	shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.		
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	Not all documents reviewed indicated that individuals had one to one supervision during restraints. (See examples below.) Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. All forms indicated that individuals were checked for restraint related injuries. Observation of the individual restrained was not consistently documented every 15 minutes as required by Appendix A. Some examples where this did not occur include restraint incidents for Individual #422 on 6/23/10, 6/29/10, 7/2/10, and 7/26/10. The state revised the restraint checklist on 6/3/10. The facility was not using the current form to document restraints. The facility needs to ensure that all future restraints are documented on the current restraint checklist form and checklists are completed accurately. The facility was rated as being in noncompliance with this provision item.	Noncompliance
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	According to documentation provided by the facility, there were 43 individuals with safety plans in place at the facility who required the use of restraints more than three times in any rolling thirty-day period. It was found that psychological assessments and resulting plans were not always adequate in addressing supports needed by individuals at the facility. As evidenced by the high number of restraints implemented at the facility, plans developed did not offer staff effective strategies to be implemented for behavioral intervention. For example,	Noncompliance

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		Individual #422 had a behavior support plan and safety plan in place, but neither offered the support staff a range support strategies prior to restraint implementation. Her safety plan had not been updated since 3/10 even though she had a significant increase in restraint incidents since the plan was written. See section K of this report for additional comments on the adequacy of behavioral supports. The facility was rated as being in noncompliance with this provision item.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	It was not evident from PSP Addendums that PSTs discussed these factors in the occurrences of restraints. Also see comments in C7 above.	Noncompliance
	(b) review possibly contributing environmental conditions;	It was not evident from PSP Addendums that PSTs discussed contributing factors to restraints. A Restraint Reduction Committee meeting was observed during the monitoring visit. Committee members agreed that there had been a direct correlation in the increase of restraints with recent moves of individuals into new homes at the facility. Again, for example, Individual #422 had the highest number of restraints in the months prior to the monitoring visit, yet there was no evidence that the team planned for her transition into a new home and addressed behavioral supports that she may need during the transition, consequently, she had exhibited an increase in behavioral episodes following the transition. Also see comments in C7 above.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	See comments in C7 above.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	See comments in C7 above.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to	PBSPs did not offer adequate strategies for staff to implement prior to the use of restraints. See additional comments addressing the adequacy of behavioral supports in section K of this report.	Noncompliance

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	be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;		
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	Although, PBSPs and safety plans had been developed as required, it was found that plans were not consistently implemented or revised as necessary when not effective. Plans did not offer the staff adequate strategies to implement during behavior crisis, as noted in section C1 and section K.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	See comments in C7 and C7f above	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	Restraint documentation was reviewed by the unit directors and the Incident Management Team. There was no indication that incorrect procedures or errors in documentation were noted or addressed with staff. In the examples listed throughout this section, there was no indication that problems were noted even though administrative staff had reviewed each incident. The Human Rights Committee (HRC) met weekly to review all restraints and restrictive practices. An HRC meeting was observed the week of the monitoring visit. The committee reviewed restraints and restrictions by reading documentation of the incident or requests submitted by PSTs for approval of the restriction. The HRC held very minimal discussion around why a restriction might be necessary or how the use of the restriction might be reduced. HRC members were apologetic when they interrupted the chairperson to ask a question. The HRC committee appeared to be considered a necessary bureaucratic exercise rather than a true advocacy process for individuals at the facility. The HRC chairperson needs to encourage open discussion among committee	Noncompliance

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		members in order to ensure the committee is being proactive in advocating for the individual's rights. PSTs met to discuss restraint incidents and address behavior, however, as noted throughout this report, these meeting were often just a routine review of incidents without a focus on revising supports when current supports were not adequate or effective. The facility was rated as being in noncompliance with this provision item.	

Recommendations:

1. Formalize the Restraint Reduction Committee's review of restraint trends and use this committee to analyze data and develop action steps to further reduce the use of medical and dental restraints at the facility.
2. All restraints should be documented in accordance with state policies.
3. All restraints should be monitored according to guidelines in state policies.
4. Train all staff to recognize when an individual is no longer a risk and may be released from restraints.
5. Train restraint monitors to identify and intervene in appropriate restraint procedures.
6. Develop behavior support plans that provide support staff with concrete strategies for deescalating behavioral incidents specific to each individual.
7. Ensure that staff know restraints should only be used as a last resort measure for crisis intervention.
8. Revise behavior support plans if they are not effective tools for direct support staff responsible for implementation of the plan.
9. The HRC chairperson needs to encourage open discussion among team members in order to ensure the committee is being proactive in advocating for individual's rights.

The following are offered as additional suggestions to the facility:

10. Teams need to meet and develop transition plans prior to major changes in the lives of individuals at the facility. To the extent possible, individuals should be involved in planning for the transition.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o MSSLC Policy: Abuse and Neglect 7/15/10 o DADS Policy: Incident Management #002.2, dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o MSSLC Chronic Caller List 5/24/10 o Incident Management Committee meeting minutes for June 2010 and July 2010. o List of most recent incidents of peer to peer aggression o Training transcript for last three employees hired o Background check for last 10 employees hired o Training transcripts for four facility investigators o Training transcripts for 14 DFPS investigators o Training transcript for 10 direct care staff o Background check for three experienced employees o Background check for the last three volunteers o Signed forms regarding reporting of abuse and neglect for 11 of the 12 staff requested o Log of Injuries by Individual (1/1/10-6/30/10) o Sample of investigations for three serious injuries involving: • Individual #227, Individual #253, and Individual #53 o Injury reports for the past six months for: • Individual #506 -16 total (2 serious) • Individual #534- 8 total (2 serious) • Individual #227 – 7 total (1 serious) • Individual #518 – 5 total (1 serious) • Individual #426 – 24 total (no serious) • Individual #110 – 30 total (no serious) • Individual #6 – 15 total (no serious) o Injury Data FY06-FY10 o Unusual Incidents Trend Analysis FY05-FY10 o Documentation of employee disciplinary action taken with regard to four incidents of confirmed abuse or neglect o Log of all A/N/E allegations since 1/1/10 including case disposition and any employee disciplinary action taken o Log of employees reassigned due to ANE allegations (1/1/10-6/30/10) o Unusual Incident Investigation Reports: • #100804XX; #100604 XX; #100725XX; #100725XX; #100725XX2; #100727XX;

#100727XX; #100726XX; #100726XX; #100726XX; #100724XX; #100723XXXX, #100404XX; #100308XX; #100308XX; #100325XX; and #100402XX.

- Documentation from the following completed DFPS investigations:

Case #	Allegation	Disposition	Date/Time of APS Notification	Date Completed
36654849	Emotional/Physical Abuse	Unsubstantiated	6/14/10 9:19 am	6/23/10
37357020	Emotional Abuse	Unconfirmed	8/9/10 10:56 am	8/19/10
37136211	Sexual Incident/Neglect	Unconfirmed	7/23/10 1:22 pm	8/2/10
36855251	Emotional/Physical Abuse	Unfounded	6/30/10 10:55 am	7/8/10
36848829	Emotional Abuse	Unconfirmed	6/29/10 6:18 pm	7/08/10
37357020	Emotional Abuse	Unconfirmed	8/09/10 10:56 am	8/19/10
37358760	Emotional Abuse	Unconfirmed	8/09/10 12:39 pm	8/19/10
36879509	Physical Abuse	Unfounded	7/01/10 4:50 pm	7/07/10
36711870	Neglect / Sexual Incident	Unfounded	6/14/10 8:30 pm	7/12/10
36817873	Emotional Abuse	Unconfirmed	6/27/10 8:38 pm	6/30/10
36836089	Emotional/Verbal Abuse (3)	Unfounded	6/29/10 9:20 am	7/06/10
37286440	Emotional Abuse	Unfounded	8/04/10 8:56 am	8/17/10
37238940	Physical Abuse	Unconfirmed	8/01/10 9:38 am	8/09/10
37238961	Emotional/ Verbal Abuse (4)	Unfounded	8/01/10 9:48 am	8/06/10
37331260		Unconfirmed	8/06/10 3:40 pm	8/16/10
36936769	Emotional Abuse	Unconfirmed	7/07/10 12:07 pm	7/13/10
36936349	Emotional Abuse	Unconfirmed	7/07/10 1:57 pm	7/16/10
37061552	Physical/	Unconfirmed	7/17/10	8/16/10

	Emotional Abuse		2:17 pm	Extensions(2)
37084129	Physical Abuse	Inconclusive	7/20/10 9:47 am	7/28/10
37081477	Neglect/ Emotional/Physical (15)	Unconfirmed (15)	7/19/10 11:28 pm	7/29/10
37088929	Emotional / Verbal Abuse	Unconfirmed	7/20/10 12:03 pm	8/04/10
37106629	Neglect (24)	Unconfirmed (18) Confirmed (6)	7/21/10 3:00 pm	8/10/10
37095053	Physical/ Emotional Abuse (2)	Unconfirmed	7/20/10 6:24 pm	7/29/10
37096989	Physical Abuse	Unfounded	7/21/10 7:34 am	7/29/10
37103969	Neglect/ Exploitation	Unconfirmed	7/21/10 1:37 pm	8/10/10
37110291	Neglect	Unconfirmed	7/21/10 5:51 pm	7/30/10
36879431	Emotional Abuse (4)	Unfounded	7/1/10 5:15 pm	7/08/10 Extensions(2)
36896755	Exploitation	Unconfirmed (3)	7/03/10 3:09 pm	8/02/10
36898461	Physical Abuse	Unconfirmed	7/04/10 2:56 pm	7/14/10
37061552	Physical/Emotional Abuse	Unconfirmed (1) Inconclusive (1)	7/17/10 2:17 pm	8/16/10 Extensions
36641069	Neglect/ Physical Abuse	Confirmed (7) Unconfirmed (7) Inconclusive(7)	6/11/10 2:33 pm	6/28/10
37006349	Neglect/Physical Abuse	Inconclusive (1) Confirmed (2)	7/13/10 3:05 pm	8/04/10
35707017	Sexual Abuse	Confirmed	3/25/10 6:45 pm	5/27/10
36067849	Neglect (Serious Injury)	Confirmed	4/23/10 11:01 pm	5/21/10
36702729	Abuse/Neglect	Confirmed	6/17/10 9:34 am	7/12/10
36500649	Abuse/ Neglect	Unconfirmed	5/29/10 11:04 pm	7/06/10
37286720	Neglect/Physical Abuse	Unconfirmed	8/04/10 8:31 am	8/13/10
37302920	Neglect/ Sexual Abuse	Confirmed (2)	8/4/10	8/10/10

		Inconclusive (1)	10:31 pm	
37296980	Neglect/Physical Abuse	Unconfirmed	8/4/10 4:07 pm	8/13/10
37270440	Neglect	Unsubstantiated	8/02/10 4:50 pm	8/23/10
36702729	Neglect/Physical Abuse	Inconclusive (2) Confirmed (2)	6/17/10 9:34 am	7/12/10

(#) indicates multiple allegations

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs
- Valerie McGuire, QMRP Director
- Dr. Charlotte Kimmel, Psychology Services Director
- Charles Bratcher, Quality Services Management Director
- Lloydette Harris, Human Rights Officer
- Pat Samuels, Incident Management Coordinator
- Lynda Mitchell, Assistant Ombudsman
- Justin Vest, Risk Manager

Observations Conducted:

- Observations at all residences
- Observations at the onsite workshop, greenhouse, and active treatment classrooms
- Informal interviews with individuals in various homes and day programs
- Observations at all residences
- Observations at the onsite workshop
- Shamrock Unit Meeting 9/14/10
- Daily Incident Management Meeting 9/14/10
- Daily Incident Management Meeting 9/15/10
- PSPA for Individual #300 9/15/10
- PSP for Individual #378 9/13/10
- PSP for Individual #37 9/16/10
- Observation of video surveillance
- Whiterock Health Status Team meeting 9/14/10
- Human Rights Committee meeting 9/14/10

Facility Self-Assessment:

The facility's self-assessment, its POI, for section D indicated that all items were in noncompliance, though comments for each item of the POI indicated that the facility was in substantial compliance with many items. The POI did not indicate how the rating of noncompliance was determined for each item. The facility needs to determine how substantial compliance will be assessed and develop a plan of action to

	address any deficiencies noted. The monitoring team is in agreement with the noncompliance rating for a majority of items in this provision. The team, however, did rate some provisions of section D as being in substantial compliance based on evidence reviewed by the team. For example, it was found that individuals and their LARs knew how to report allegations of abuse and neglect to DFPS. This was evidenced by the number of allegations reported by individuals and their family members. The facility was also in substantial compliance with provisions addressing their cooperative working relationship with OIG and other outside entities. The facility had made efforts since the baseline monitoring visit to develop a better working relationship with OIG and DFPS and clarify any confusion regarding the role of each agency. Evidence reviewed for monitoring of section D included documentation, observation at the facility, and interviews with staff.
	Summary of Monitor's Assessment: The number of spurious allegations at MSSLC continued to be a unique challenge for the facility. Numerous staff hours were allocated to investigations, meetings at all levels, and paperwork/data entry as a result of the high number of allegations. Staff were routinely pulled off of their regular job assignments due to allegations of abuse and neglect, leaving many individuals at the facility at risk due to inadequate staff ratios and untrained direct care staff filling in for employees reassigned. Direct care and residential supervisory staff in homes throughout the facility cited concerns over being able to provide adequate supports to individuals due to regular staff being pulled to work in other homes, and having pulled staff assigned to homes who were not familiar with the individual's support needs working in the homes. It was found during informal interviews with direct care staff throughout the facility that while most staff were able to describe risks and interventions for the individuals whom they were assigned to support, there were some staff on duty that did not know the specific risks for individuals and, in one case, a direct support staff person at M4 did not even know the name of an individual whom she was assigned to support. She was alone in a room with three individuals and reported that she had been assigned to that area of the day program because they needed coverage. According to a log of investigations provided to the monitoring team, 997 allegations of abuse, neglect or exploitation were conducted by DFPS at the facility from 1/1/10 through 7/27/10. Of these 997 allegations, 69 (7%) were confirmed by DFPS. This included 23 confirmed allegations of physical abuse, 3 confirmed allegations of sexual abuse, 40 confirmed allegations of neglect, 12 confirmed allegations of verbal or emotional abuse, and one confirmed allegation of exploitation. The facility's trend analysis report for FY10 showed a total of 1,313 abuse/neglect investigations had been conducted in FY10 with one month remaining in the fiscal year. This was an increase of 35 cases compared to the same time period during FY09. The report noted that there had been an upward trend in reported cases from FY06 to FY10. This increase was attributed to "individuals making false allegations coupled with a large number of individuals who are vocal and who use the system for their own benefit, such as removal of unwanted staff or to take revenge on other individuals in the home." The report did not analyze trends for the significant number of confirmed allegations at the facility. Many of the DFPS completed cases involved multiple allegations against a particular alleged perpetrator, while other cases involved multiple

	alleged perpetrators accused of abuse or neglect involving one individual. This was an alarming number of confirmed allegations of abuse and neglect. The facility needs to immediately examine facility trends and develop a plan of correction to address any trends identified in confirmed cases. One concern of the monitoring team regarding incidents at the facility was the lack of documented follow-up to ensure corrective actions were taken to prevent additional incidents. There were four full-time investigators employed by the facility. According to the incident management coordinator, all internal investigations were completed by the four investigators. The facility was averaging around 100 investigations per month. If the investigations were handled equally by those four investigators, this would have been more than one investigation per working day for each of the investigators. It was noted during observation at the facility that investigators spent a portion of each day attending incident management meetings, typing reports, making notifications, and collaborating with outside investigators and other facility personnel. It was unlikely that investigators had enough time to complete thorough investigations and follow up to make sure documents were reviewed and follow-up information was included in completed investigations. There were a total of 3,463 injuries reported during the first three quarters of FY10. This was an increase of 28 injuries when compared with the first three quarters of FY09. The facility trended those injuries by home and by shift, but not by injury type or cause. According to a log of all injuries since 1/1/10, there had been 66 serious injuries requiring medical intervention or hospitalization. One individual had four serious injuries, six individuals had two serious injuries, and 60 other individuals each had one serious injury during this time period. Nineteen of the serious injuries were attributed to peer to peer aggression. The facility needs to trend injuries by cause and implement injury prevention strategies when possible. While it was useful to identify where the injuries are occurring, without identifying the cause or type of injuries occurring most often, this information was not adequate for developing a plan of correction to reduce the number of injuries. Video surveillance cameras had been installed in common areas throughout the facility since the baseline monitoring visit. A review of incident investigations indicated evidence from the surveillance cameras was being used in investigations. It was reported in interviews during the monitoring visit that this evidence was beneficial in confirming abuse and neglect in cases where evidence might not otherwise have been available to support the allegations. It was a concern, however, that cameras were often not working in homes where the greatest number of allegations were made. According to one of the facility's program auditors, individuals living in some of the homes routinely damaged the cameras. The DFPS investigator made the following statement in case #37357020: "There was a concern that video cameras in the Whiterock 6 home have not been replaced after being destroyed. Cameras would have helped the investigation." The facility was trying to address this problem during the monitoring visit by making some of the cameras less accessible to individuals in the home. Some of the items in this provision were found to be in substantial compliance, though the majority were

	found to be in noncompliance.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	Assessment of this item required review of policies and an examination of implementation of those policies. The state had recently updated policies regarding Incident Management and Protection from Harm. The Incident Management Policy numbered 002.2, and was dated 6/18/10. It included a number of addenda and forms, such as regarding unusual incidents, high profile incidents, and client injury reporting procedures. The Protection for Harm - Abuse, Neglect, and Exploitation policy was also Revised 6/18/10 and numbered 021. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. All staff were required to report suspected abuse, neglect, and exploitation. There were posters regarding this mandate posted in each facility location visited, but the posters were not all identical, making it difficult to locate the correct information. It is recommended that the facility post identical posters throughout the facility and train staff and individuals to look for the information on that poster. When interviewed, some direct care staff stated that they would call their supervisor first if they suspected abuse or neglect. The facility needs to ensure that staff knows to call the 800# first if they suspect abuse or neglect. The Director of Quality Service Management reported that that the facility was in the process of updating its Incident Management Policy to address concerns unique to MSSLC. The facility was rated as being in noncompliance with this provision item.	Noncompliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for	The state policy specified reporting requirements for all serious incidents and was in line with this provision item. The facility policy included a section on incident reporting responsibilities for determining to whom incidents should be reported, and within what time frame. The facility utilized a standardized reporting form for all serious injuries and incidents. Unusual Incident Reports documented notification to the Director/Designee,	Noncompliance

#	Provision	Assessment of Status	Compliance
	deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	After-Hours Duty Officer, Risk Management, Investigator, Campus Coordinator, Director of Psychology, Unit Director, QMRP, Correspondent, DFPS, Law Enforcement, State Office, OIG, and DADS Regulatory. A sample of 166 unusual incident reports, investigations, and injury reports were reviewed. The agency used form SMRF001 to document all serious incidents. All reports included an area to document notification date and time to the facility director, DFPS, law enforcement, the state office, and DADS regulatory. DFPS was responsible for notifying local law enforcement or OIG. OIG notified the facility of outcomes of investigations by email. It was noted that all notifications made to OIG and the state office were documented as occurring at 9:00 am the morning following the incident. It seems unlikely that this was the actual time of notification, since on many days there were multiple incidents where the IMT had notified the facility director, OIG, and/or the state office, all at 9:00 am. The following were some examples of notifications documented in investigations reviewed: • UIR #100604XX indicated that a serious injury occurred at 5/24/10 at an unknown time. The director was notified on 6/4/10 at 11:25 am. DFPS and DADS regulatory were not notified until 6/8/10, and the state office was not notified until 6/9/10. The report indicated that the injury was not deemed serious by the physician until 6/4/10, though a witness statement from the direct care staff indicated that she was informed of the fracture on 5/24/10. • UIR #100804XX indicated that the facility learned of an abuse and neglect allegation on 8/4/10 at 12:25 pm from DFPS. The facility director was notified 35 minutes later. No other notifications were warranted. • UIR #100402XX indicated that the facility learned of an abuse allegation on Friday, 4/2/10 at 2:39 pm by DFPS. The director was notified three minutes later, the facility notified OIG and the state office on Monday, 4/5/10 at 9:00 am. • UIR #100325XX indicated that the facility was notified of an abuse allegation on 3/25/10 at 5:53 pm by DFPS. The facility director, OIG and the state office were all notified the following morning at 9:00 am by facility staff. • UIR #100308XX indicated that the facility was notified of an abuse allegation on 3/8/10 at 9:00 pm. The facility director was notified 35 minutes later. OIG and the state office were notified at 9:00 am the following morning. • UIR #100308XX indicated that the facility was notified of an abuse allegation on 3/8/10 at 5:23 pm. The facility director, OIG, and the state office were notified at 9:00 am the following morning. • UIR #100404XX indicated that the facility was notified of an abuse allegation on 4/4/10 at 12:51 am. The facility director, OIG and the state office were notified at 9:00 am the following morning.	

#	Provision	Assessment of Status	Compliance
		• UIR #100727XX indicated that the facility was notified of an abuse allegation on 7/27/10 at 11:20 am. The facility director was notified at 11:33 am and the state office was notified at 9:00 am the following morning. The report indicated DFPS notified OIG. • UIR #100727XX indicated that the facility was notified of an abuse allegation on 7/27/10 at 9:52 am. The facility director was notified at 10:32 am and the state office was notified at 9:00 am the following morning. The report indicated DFPS notified OIG. • UIR #100723XXXX indicated that the facility was notified of a sexual incident on 7/23/10 at 12:05 pm. The facility director was notified at 12:46 pm, DADS regulatory was notified on 7/24 at 4:00 am, and the state office was notified at 9:00 am on 7/26/10. The report indicated DFPS notified OIG. • UIR #100726XX indicated that the facility was notified of an abuse allegation on 7/26/10 at 8:50 pm. The facility director was notified at 9:02 pm and the state office was notified at 9:00 am the following morning. The report indicated DFPS notified OIG. • UIR #100726XX indicated that the facility was notified of an abuse allegation on 7/26/10 at 7:03 pm. The facility director and the state office was notified at 9:00 am the following morning. The report indicated DFPS notified OIG • UIR #100726XX indicated that the facility was notified of an abuse allegation on 7/26/10 at 5:43 pm. The facility director and the state office was notified at 9:00 am the following morning. The report indicated DFPS notified OIG • UIR #100726XX indicated that the facility was notified of an abuse allegation on 7/26/10 at 12:04 pm. The facility director was notified at 12:12 and the state office was notified at 9:00 am the following morning. The report indicated DFPS notified OIG. The facility needs to document actual time of notification to other entities. Eighteen new employees had been hired for video surveillance at the facility. Interviews with video monitors during the review indicated that they had been trained in recognizing abuse and neglect and were aware of their responsibility to report abuse and neglect if observed during video surveillance. There were posters located throughout each facility site that provided basic instructions on intervening to stop abuse, as well as reporting abuse. As noted in section D1 above, the facility needs to use one identical posting of the DFPS 800# throughout the facility to make it easily identifiable to staff and individuals. The facility was rated as being in noncompliance with this provision item.	

#	Provision	Assessment of Status	Compliance
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	A review of Incident Management Team (IMT) meeting minutes, observation of IMT meetings, and observation of morning Unit meetings confirmed that the facility took immediate and appropriate action to protect individuals involved in serious incidents. Alleged perpetrators were immediately removed from direct contact with individuals and reassigned to other duties until investigations were completed. This was confirmed by a list of employees reassigned due to ANE investigations provided to the monitoring team. The Incident Management Coordinator was interviewed during the review week and reported 47 staff members were reassigned on that day due to allegations. He stated that there were rarely less than 10 staff reassigned on any given day. A list of employees reassigned due to allegations was reviewed at the Daily Incident Management meetings. As noted in the summary section for provision D, the number of employees reassigned due to allegations contributed to problems throughout the facility and placed individuals at risk. Nursing staff completed injury assessments on individuals involved in all serious incidents. Levels of supervision were routinely increased when deemed appropriate for individuals involved in any type of serious incident until team members could determine that the increased level of supervision was no longer necessary. A review of individuals on one-to-one supervision at the time of the onsite monitoring visit indicated that individuals were placed on heightened supervision for medical monitoring, to minimize the risk of aggression towards others, to minimize the risk of self-injury, and to minimize the risk of injury. Observation at the facility and a review of PSPAs indicated that PSTs met following most incidents to review the incident. Staff from each discipline attended these meetings and had input into the discussion. Additional comments regarding the effectiveness of these team meetings can be found in other areas of this report. Incidents were also discussed each day during shift change meetings in individual homes, then at morning unit meetings, and at daily Incident Management Team meetings. Additional recommendations for protections were occasionally made at Incident Management meetings, though IMT meetings observed and meeting minutes reviewed indicated that the IMT did a cursory review of incidents without thorough consideration of supports that may need to be revised to address the incident. For example: • IMT meeting minutes from 6/21/10 reviewed indicated that the IMC reviewed five restraint incidents for one individual, but did not make any recommendations for addressing the increase in behavior incidents for the individual.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• IMT meeting minutes from 7/28/10 indicated DADS made several recommendations in regards to a death at the facility. The recommendations were listed in the minutes, but there was no indication that the facility would follow-up on those recommendations or that they would be reviewed further. • IMT meeting minutes from 7/20/10 indicated that the IMT reviewed a serious injury due to a fall for Individual #227. Injury reports from 3/19/10 through this date indicated this individual had four other injuries due to falls prior to the serious injury. Meeting minutes stated "team met and made no changes. PT will see her sometime this week for an evaluation." There were no recommendations from the team or other immediate prevention strategies implemented to safeguard the individual. There were two additional falls documented in injury reports following this incident. Although the facility took a number of steps to safeguard individuals when serious incidents occurred, the IMT needs to make recommendations regarding safeguarding individuals when appropriate and document follow-up to those recommendations. The facility was rated as being in noncompliance with this provision item.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The facility provided initial training and annual retraining on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation. All staff were required to complete ABU0100 Abuse and Neglect and UNU0100 Unusual Incidents initially upon employment and every 12 months thereafter. Documentation of training was kept by the facility and a sample of 16 staff training transcripts was reviewed. This review indicated that the facility was not in compliance with the mandate to complete training at least yearly. • A review of training transcripts for the last three employees hired indicated that all three had completed initial courses ABU0100 and UNU0100 as required. • A review of training transcripts for the four facility investigators indicated that none of the four had completed ABU0100 and UNU0100 at least yearly. All had completed the two courses, but not annually as required. • A review of nine other employee's training transcripts indicated that five of the employees had completed ABU0100 within 12 months as required and four had not. There was no indication that three of the nine employees had completed UNU0100 training in the past two years. Five had completed the course, but not within 12 months as required, and one was in compliance with training requirements for completing UNU0100. The facility needs to ensure that all employees receive annual training as required by the	Noncompliance

#	Provision	Assessment of Status	Compliance
		state policies on abuse and neglect and incident management. The facility was rated as being in noncompliance with this provision item.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	The policy addressed mandatory reporters. Initial staff training provided during orientation included information on recognizing and reporting abuse and neglect. All staff who were interviewed were aware of their obligation to report. In all facility buildings toured during the review, posters stating the obligations of mandatory reporters were posted in common areas. There were a lot of posters throughout the facility that were outdated, making it hard to find necessary information posted in some buildings. Keys were not available for some encased bulletin boards so staff were unable to remove the old posters. Staff were required to attend annual training on reporting abuse and neglect, but as noted in section D2c, not all staff had received training as required. The facility policy required staff to sign a statement acknowledging their responsibility to report abuse, neglect, and exploitation. A sample of staff personnel records was requested (for 12 employees). Signed statements were available for 11 of the 12 employees. The facility was rated as being in noncompliance with this provision item because staff had not received annual training as required regarding their obligation to report and that information was not readily available to them throughout the facility.	Noncompliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The policy stated that a training and resource guide on recognizing and reporting abuse and neglect will be provided by the facility to all individuals and their LARs at admission and annually. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. PSPs indicated that information regarding reporting of abuse and neglect was shared with families. A review of abuse and neglect investigations indicated that at least some of the individuals and their family members were aware of reporting procedures and had reported suspected abuse and neglect incidents to DFPS. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and	Posters were found posted in common areas throughout the facility with a statement of individuals' rights. These posters included information on reporting violation of rights.	Noncompliance

#	Provision	Assessment of Status	Compliance
	easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	Information on the poster was clear and easy to understand, including pictures for individuals who could not read. Posters need to be updated throughout the facility to identify the newly appointed Rights Officer and the correct Ombudsman. Numerous posters found throughout the facility had incorrect or outdated information regarding contact persons for rights violations. The facility was rated as being in noncompliance with this provision item.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The state policies included procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement. DFPS was responsible for making the determination of when it was appropriate and following through with reporting. The Incident Management Coordinator confirmed that DFPS routinely referred cases to law enforcement and the facility verified that cases were referred as required. In a sample of investigations reviewed, all 24 of the cases that required reporting were correctly referred to law enforcement, OIG, or both by DFPS. The QSM Director reported that the facility had met with OIG since the last monitoring visit to clarify their roles and establish a better working relationship. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	Policy specified how to report retaliatory action and stated that employees engaging in retaliatory action were subject to employee disciplinary procedures. All staff interviewed stated that they were not hesitant to report suspected abuse, neglect, or mistreatment, and were able to state to whom incidents of abuse, neglect, and mistreatment should be reported. No cases of retaliatory action or allegations of retaliatory action were found by the monitoring team. All direct care staff interviewed during the monitoring visit indicated that they must report allegations of abuse or neglect to their supervisor, as well as, to the DFPS 800#. Some staff indicated that they were required to report suspected abuse to their supervisor before DFPS. While in some cases this would be beneficial to the facility (e.g., so that management may begin taking steps to safeguard the individual), it may also inhibit staff from reporting as well as be counter to state regulations. The facility needs to ensure that staff know to report to DFPS first and that failure to report abuse or neglect to the facility director is not grounds for disciplinary action. The facility was rated as being in noncompliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	There was no evidence that formal audits were conducted to determine whether significant resident injuries were reported for investigation. The following details findings from a review of a sample of serious injury reports and corresponding UIRs. • Individual #506 had 16 reported injuries since 3/1/10. Fourteen were listed as non-serious injuries and two were listed as serious injuries. Investigations (UIR #100823 and UIR #100310) were completed on the two injuries deemed serious. The individual was referred to the emergency room by the facility physician for one of the injuries deemed non-serious where a CT scan was performed and Dermabond was used for wound closure. According to the state policy, this constituted a serious injury. There was not an investigation of this injury. • Individual #518 had five reported injuries since 3/1/10. Four were listed as non-serious and one as serious. A UIR was not found for the serious injury dated 7/30/10 requiring seven sutures. • Individual #534 had a total of eight injuries since 3/1/10 including two serious injuries. Investigations were completed on the two serious injuries (UIR #100629 and UIR #100806). • Individual #227 had a total of seven injuries since 3/1/10, including one serious injury. The serious injury was investigated by the facility and documented as UIR #100718. • Individual #459 had a serious injury of unknown cause that was investigated by the facility. It occurred on 5/24/10, but was not reported to DFPS until 6/8/10. • Individual #543 had a serious injury of unknown cause that was investigated by the facility. The injury was identified as a broken wrist. The facility did not report the injury to DFPS for investigation. The individual's correspondent filed a neglect allegation regarding the injury on 8/6/10. The facility needs to develop a process to ensure that all significant injuries are investigated. The facility was found to be in noncompliance with this provision item.	Noncompliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such		

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>policies and procedures shall:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.</td><td>The state policy addressed the conduct of investigations and qualifications of investigators. The policy stated “within one (1) month of employment or assignment as an investigator, and prior to completing an Unusual Incident Report (UIR), all investigators who are responsible for completing any part of the UIR must complete the courses, “Comprehensive Investigator Training (CIT0100)” and “People with MR (MEN0300).” The policy further mandated that all Incident Management Coordinators and facility investigators “must “Conducting Serious Incident Investigations or Fundamentals of Investigation” training (INV0100) and a class in Root Cause Analysis.”

Training documentation for the four facility investigators was reviewed. These were the only employees assigned to complete investigations at the MSSLC. Each investigator had completed numerous courses related to investigations and incident management including:

<table>
<tr><th>Course</th><th>Investigator 1</th><th>Investigator 2</th><th>Investigator 3</th><th>Investigator 4</th></tr>
<tr><td>CIT 0100 Comprehensive Investigator Training</td><td>2/17/08</td><td>4/4/07</td><td>4/4/07</td><td>Not documented</td></tr>
<tr><td>INV0100 LRA Fundamentals of Investigation</td><td>12/15/09</td><td>4/5/05</td><td>4/5/05</td><td>12/15/09
1/13/09</td></tr>
<tr><td>UNU0100 Unusual Incidents</td><td>1/7/09*
4/17/07</td><td>4/8/10*
1/9/08</td><td>4/6/10*
4/7/08</td><td>12/3/08*
3/19/07</td></tr>
<tr><td>FIM1000 Facility Incident Mgmt</td><td>12/10/08</td><td>12/10/08</td><td>12/10/08</td><td>12/10/08</td></tr>
<tr><td>INV1002 Investigation Combinations</td><td>11/17/08</td><td>11/17/08</td><td>11/7/08</td><td>11/17/08</td></tr>
<tr><td>SER1000 Incident Management</td><td>1/12/09</td><td>7/30/08</td><td>7/30/08</td><td>9/8/08</td></tr>
<tr><td>DAD1001 DADS Regulatory Reporting Responsibilities</td><td>8/18/09</td><td>8/18/09</td><td>8/18/09</td><td>8/18/09</td></tr>
</table>
</td><td>Substantial Compliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>OBS0100 Observing and Reporting</td><td>2/25/08</td><td>3/8/05</td><td>10/17/03</td><td>9/8/08</td></tr>
<tr><td>ABU0100 Abuse and Neglect</td><td>3/31/10
1/12/09*</td><td>1/13/10
7/30/08*</td><td>1/13/10
7/30/08*</td><td>12/1/09
9/8/08 *</td></tr>
<tr><td>CSI0100 LRA Conducting Serious Investigations</td><td>12/15/09</td><td></td><td></td><td>12/15/09</td></tr>
</table>
* = more than 365 days

All of the investigators had completed INV0100 and two had completed training on Conducting Serious Investigations. None of the four investigators was in compliance with the state mandate to complete Root Cause Analysis or ABU0100 and UNU0100 training every 12 months. Each investigator had completed training related to working with individuals with developmental disabilities including: MEN 0300 People with Mental Retardation, PER 0200 Person Directed Treatment, RIG0100 Rights of Consumers, and PBS0100 Positive Behavior Support.

Training transcripts were provided to the monitoring team for 14 DFPS investigators. Thirteen of the investigators had completed training on working with individuals with developmental disabilities, one had not.

The policy also stated that the investigator would not be in the direct line of supervision of the alleged perpetrator. There was no evidence that this was not the case.</td><td></td></tr>
<tr><td></td><td>(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.</td><td>The facility policy mandated that staff cooperate with all investigations at the facility. The Director of Quality Service Management reported a good working relationship with DFPS, local law enforcement, and OIG. There was no evidence that the facility had not cooperated with outside investigations.

The facility was rated as being in substantial compliance with this provision item.</td><td>Substantial Compliance</td></tr>
<tr><td></td><td>(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.</td><td>There was no evidence of interference with investigations completed by law enforcement agencies. As noted in other sections of this report, cases were referred to local law enforcement or OIG, but details of those investigations were not included in investigation files.

The facility was rated as being in substantial compliance with this provision item.</td><td>Substantial Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	(d) Provide for the safeguarding of evidence.	The state policy mandated that the facility investigator should prioritize the collection of evidence that is at most risk of contamination. It was evident that facility staff were quick to react to incidents and begin preliminary investigations. As noted in (e) below, there were some concerns over the ability of the facility to safeguard evidence when DFPS investigations did not always commence in a timely manner and/or were not completed in a timely manner. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	The state policy addressed timelines for investigations. While DFPS policy allowed for the initial facility notification of an allegation to be the start of an investigation, the monitoring teams viewed the first attempt to gather information at the facility as a starting point for the investigation. Several concerns that arise from this practice include, the opportunity to tamper with evidence, the opportunity for collaboration between perpetrators and staff, and the victim's inability to recall events after time has lapsed. Therefore, while investigations met DFPS requirements, many did not meet the requirement of the Settlement Agreement to commence the investigation within 24 hours. The following are examples where initial attempts to gather information did not commence within 24 hours of notification: • DFPS investigation #37106629: a neglect allegation was reported on 7/21/10 at 3:00 pm. The initial face-to-face investigation did not occur until 7/23/10 at 12:51 pm. The investigation was not completed until 8/10/10, not meeting the 10 day requirement for completion of cases. • In DFPS investigation #37103969, allegations of neglect and exploitation were reported on 7/21/10 at 1:37 pm, the initial face-to-face investigation did not begin until 7/23/10 at 11:55 am, not meeting the requirement to commence within 24 hours. • In DFPS investigation #37061552, allegations of emotional and physical abuse were reported to DFPS on 7/17/10 at 2:17 pm, and the initial face-to-face contact occurred in a timely manner at 9:10 am on 7/18/10, but the case was not completed until 30 days after the initial report on 8/16/10. The investigation report noted that extensions were filed, but there was no explanation for the lengthy delay in completing this case. • In DFPS investigation #36879431, an allegation of emotional abuse was reported to DFPS on 7/1/10 at 5:15 pm. The first face to face interview was not conducted until 7/3/10 at 1:50 pm. The requirement to begin investigations within 24 hours was not met in this case. • In DFPS investigation #37357020 an allegation of emotional abuse was reported	Noncompliance

#	Provision	Assessment of Status	Compliance
		to DFPS at 10:56 am on 8/9/10. The initial face to face investigation did not take place until 8/11/10 at 1:47 pm. • In DFPS case #36500649, the initial notification was made on 5/29/10. The investigation took 38 days to complete. DFPS had updated its policy to require completion of investigations within 10 days beginning 6/1/10. Prior to 6/1/10, DFPS policy mandated completion of investigations in 14 days. Numerous investigations reviewed were not completed as mandated by DFPS policy or this provision including: • DFPS #36641069 completed in 17 days. • DFPS #35707017 completed in 62 days • DFPS #36067849 completed in 28 days. • DFPS #36702729 completed in 25 days. • DFPS #36500649 completed in 38 days. • DFPS #37270440 completed in 20 days. • DFPS #37088929 completed in 14 days. • DFPS #37106629 completed in 20 days. • DFPS #37103969 completed in 19 days • DFPS #37061552 completed in 29 days. • DFPS #37088929 completed in 14 days. DFPS reports included a comprehensive summary of the investigation. Some of the investigations included recommendations for follow-up action by the facility based on information gathered during the review. All Unusual Incident Reports (UIR) completed by the facility indicated that internal investigations began as soon as the incident occurred or was discovered, usually within minutes. Individuals were examined by a facility nurse immediately in most cases. UIRs reviewed, however, rarely included recommendations and an action plan for following up on the incident. Some reports included the statement that the individual had received medical attention, but no further recommendations or follow-up were noted. The facility needs to include any recommendations for corrective action or follow-up in the UIR and indicate when the action is completed. The facility needs to ensure that attempts to begin gathering evidence in each case commence within 24 hours and investigations conclude within 10 days. When extensions have been approved by DFPS or the facility, an explanation for the extension request should be included in the report. The Director of Quality Services Management reported that DFPS had hired additional	

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		investigators and OIG had assigned two investigators to MSLLC to complete investigations at the facility. He reported that investigations were being completed in a more timely manner. The facility was rated as being in noncompliance with this provision item.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	The policy mandated consistent investigation procedures and recordkeeping including elements listed in this provision item. Investigation files were consistently compiled in a clear and easy to follow format. All investigations included the serious incident or allegation of wrongdoing, the name(s) of all witnesses, and the name(s) of all alleged victims and perpetrators (when known). Reports included a summary of topics discussed, a summary of all documents reviewed, and all sources of evidence considered. A log of previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency were included in evidence considered. The monitoring team reviewed 17 UIRs, where the investigation was completed by facility investigators. Evidence gathered was not always sufficient to provide a clear basis for the conclusion. For example: A review of Unusual Incident Investigation #100722 involving a serious injury for Individual #253 did not include staff observation notes from the actual incident. The Unusual Incident Report (UIR) indicated that an injury report and witness statement from the individual and direct care staff on duty were reviewed during the investigation, copies were not included in the final investigation report and the log on the UIR was blank in regards to which staff were on duty at the time of the incident. The Shift Home Log from the date of the incident indicated no significant events occurred regarding the individual served on that date. The only documented account of the injury included in the report was the nursing note following the incident that included a summary of what staff on duty reported to her regarding the incident. At that time, she reported that he appeared with dried blood from elbow to wrist. It was not reported as a serious injury until at least 10 hours later when the individual was seen by the physician and it was determined that the individual needed seven sutures to close the wound. This investigation did not show evidence of how the injury occurred or whether or not staff provided care in a timely manner. Furthermore, the report was not reviewed and approved by the Incident Management Committee and by the Facility Director until 29 days after the incident. A review of Unusual Incident Investigation #100729 involving a serious injury (fractured toe) for Individual #53 indicated that staff on duty at the time of the incident was not interviewed regarding the incident. The UIR did include a summary of an observation note completed by a staff person, though this staff person was not signed onto the staff	Noncompliance

#	Provision	Assessment of Status	Compliance
		work assignment log for the individual's home at the time of the incident. Investigators need to clarify any inconsistencies in evidence obtained for an investigation. The facility investigators need to ensure that evidence gathered supports witness statements and obtain proof of how injuries occurred when possible. The facility was not in compliance with this provision of the Settlement Agreement.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The state policy required that the Incident Management Coordinator review all investigations to ensure that they were thorough, accurate, coherent, and complete. All investigations were to be reviewed by the Incident Management Coordinator and the Facility Director or his designee. Investigations remained an item for discussion on the Incident Management Team Meeting agenda until cases were closed and recommendations were completed. UIRs completed for cases DFPS #36936349, DFPS #37084129, DFPS #37088929, DFPS #37103969, DFPS #37324960, and UIR #100725 did not indicate review by the IMC and the facility director or his designee. Other cases were reviewed by the facility director and incident management coordinator (IMC), but not in a timely manner. For example, • The IMC and facility director did not review case #36641069 until 8/5/10, though the investigation was completed on 6/28/10. • The IMC and facility director did not review case #36067849 until 6/28/10, though the investigation was completed on 5/21/10. • The IMC and facility director did not review case #36702729 until 8/4/10, though the investigation was completed on 7/12/10. • The IMC and facility director did not review case #36898461 until 8/9/10, though the investigation was completed on 7/14/10. • The IMC and the facility director did not review case #36654849 until 8/3/10, though the investigation was completed on 6/23/10. All completed reports should be reviewed by the IMC and reviewed and approved by the facility director as soon as possible to ensure follow-up action if necessary has been taken. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each	The state policy required the facility to complete an Unusual Incident Report (UIR) for each incident at the facility. A sample of 17 UIRs completed by the facility investigators was reviewed by the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	unusual incident.	monitoring team. Reports included a summary of investigative procedures, relevant history, personal information about the individual, a time line of notifications, and an analysis of findings and recommendations for remedial action to be taken. UIRs did not typically include corrective action steps to address issues identified in the investigation or document follow up on issues.	
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	A log of employees reassigned due to ANE allegations and observation of Unit and Incident Management Team meetings indicated that employees were routinely reassigned to duties either not requiring contact with individuals immediately when named in an abuse or neglect allegation or to other units with increased supervision. Employees did not return to their position until investigations were complete. Proof of disciplinary action for perpetrators was requested for a small sample of four confirmed cases of abuse at the facility. All confirmed perpetrators were terminated from employment by the facility in these four cases, however, a log provided to the monitoring team of disciplinary action taken in all cases with confirmed allegations did not indicate that disciplinary action was taken in all cases. For example, the log showed no disciplinary action taken in the following confirmed allegations: • Individual #57, neglect, one perpetrator • Individual #538, physical abuse, two perpetrators • Individual #191, verbal/emotional abuse, two perpetrators • Individual #286, verbal/emotional abuse, two perpetrators • Individual #179, neglect, two perpetrators (one was dismissed) • Individual #538, physical abuse, five perpetrators (one was dismissed) • Individual #140, #317, and #485, sexual abuse, three perpetrators (two were suspended) • Individual #243, neglect, one perpetrator • Individual #542, neglect, three perpetrators (two were dismissed) • Individual 3276, neglect, two perpetrators (one was dismissed) • Individual #276, neglect, two perpetrators • Individual #391, neglect, three perpetrators (one was dismissed) • Individual #426, neglect, three perpetrators • Individual #578, physical abuse, two perpetrators (one was dismissed) • Individual #57, neglect, one known perpetrator The facility needs to ensure that disciplinary action is taken in all cases of confirmed abuse and neglect and action taken is documented. The facility was found to be in noncompliance with this item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	All investigations requested by the monitoring team were quickly accessed by the facility. Data were available by individual and/or staff person involved. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility was able to provide the monitoring team with multiple logs of injuries and other incidents as requested. Incidents and allegations were trended by individual, home, location, date, and time. Trends analyzed were not available to identify cause and incident type by specific categories. While it is useful to identify where the injuries are occurring, without identifying the cause or type of incident occurring most often, this information will not be adequate for developing a plan of correction to reduce the number of injuries and incidents. The facility was found to be in noncompliance with this provision item.	Noncompliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at	The Monitoring Panel has had discussions with the state regarding how this provision of the Settlement Agreement will be assessed. This is necessary due to the confidentiality of the information, and the limited documentation that the state is allowed to maintain regarding the findings of the background checks, especially regarding applicants who are denied employment, and active employees who are terminated due to findings during their employment. To address this, the state will provide the Monitoring Teams with names of staff responsible for the process, so that they can be interviewed, and spreadsheets for each facility to allow reviews to be conducted to ensure that all staff currently employed have had the necessary checks completed. Until such information is made available, this indicator will be rated as being in noncompliance. Even so, MSSLC provided the monitoring team with some information, including a log indicating that the facility completed background checks prior to employment for the last 10 employees hired, as well as for three experienced staff.	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.		

Recommendations:

1. Implement an audit process to ensure all serious injuries are investigated thoroughly.
2. Examine facility trends and look at specific indicators to develop a plan of correction to address any trends identified in confirmed cases of abuse and neglect
3. Identical posters with information on reporting abuse, neglect, and exploitation need to be posted in all common areas throughout the facility. Individuals and staff should receive training consistent with information posted at each site.
4. Ensure that all staff knows to call the 800# first if they suspect abuse or neglect.
5. Document actual time of notification to facility staff and outside entities on incident reports.
6. The IMC needs to make recommendations regarding safeguarding individuals when appropriate and document follow-up to those recommendations.
7. The facility needs to ensure that all employees receive annual training as required by state policies on abuse and neglect and incident management.
8. Include any recommendations for corrective action or follow-up in the UIR and indicate when the action is completed.
9. Ensure that attempts to begin gathering evidence in each case commence within 24 hours and investigations conclude within 10 days.
10. Ensure that all disciplinary action is in line with the facility's zero tolerance policy for abuse and neglect.
11. Ensure that trained staff are available in adequate numbers to comply with recommended staffing ratios.

Additionally, the facility may want to consider the following recommendations:

12. Examine the workload of facility investigators to determine if they have adequate time to complete thorough investigations and complete

necessary documentation.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy #003: Quality Enhancement, dated 11/13/09 o Organizational chart, dated 8/18/10 o Table of contents/outline of MSSLC policy and procedure manuals: Brown: organizational, Green: campus, and Blue: home life and training o MSSLC POI, updated 8/26/10 o MSSLC POI Supplement, 8/18/10 o MSSLC QE Department Settlement Agreement Presentation Book o Summary sheet from opening presentation made to the monitoring team, 9/13/10 o MSSLC QE Plan, dated 8/2/10 o QA monitoring tool, dated 12/09, blank o Corrective Action Plan Tracking Spreadsheet, three items, most recent 8/18/10 o QA monitoring table (showing who was responsible for monitoring which Settlement Agreement provisions [similar to QE plan]), 10/19/09 o Blank QA monitoring tool that looks at four aspects related to ICFMR CMS regulatory requirements o Table and graphs of data for the QA monitoring tool, September 2009 through August 2010 • by unit • by each of the four areas: engagement, environment, programming, community o Total Compliance by the Month Summary 2010 table that showed a summary of all data for all of the Settlement Agreement monitoring tools in one document, and that showed data from November 2009 through September 2010. o Trend analysis: graphs with accompanying data tables and brief narrative for data from September 2005 through July 2010 and a paragraph providing some explanatory information • Unusual incidents • Abuse and neglect allegations and confirmations • Reported injuries • Restraint usage, both program and emergency o PIC meeting minutes: 1/5/10 through 9/15/10 (15 meetings) o PET meeting minutes: January 2010 through July 2010 o PET I: seven meetings o PET II: seven meetings o PET III: six meetings (began in February 2010) o Medical workload data for August 2010 o Description of changes to PIC, from Chris Adams, 9/9/10 o Agenda from QE and SAC two-day meeting, 5/26-27/10 o Variety of training documentation for QA staff: completed and scheduled o Best home of the month announcement

	o List of typical meetings that occurred at MSSLC o Numerous staffing and vacancy related documents o MSSLC Forensic Plan, 7/21/10 o DADS survey of staff engagement (satisfaction), executive summary, 2010; and DADS commissioner email to all DADS employees, dated 9/20/10 o Suggestion box items from 9/14/10 o Self-advocacy meeting minutes for the Whiterock group (three meetings) and the Shamrock group (five meetings), April 2010 through September 2010 <u>Interviews and Meetings Held</u>: o Dr. William Lowry, Facility Director o Brenda Shoemake, Assistant Director of Programs o Colleen Range, Director of Quality Enhancement o Etta Jenkins, Settlement Agreement Coordinator o Charles Bratcher, Director of Quality Services Management o Residential Unit Directors: Polly Bumpers, Bertha Allen o Lloydette Harris, Rights Officer o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: o Many residences, day program, and vocational program o Facility senior management meeting, 9/14/10 o PIC Meeting, 9/15/10 o PET III meeting, 9/16/10 o Self-advocacy meeting, 9/15/10
	Facility Self-Assessment: The facility completed its self-assessment for this provision, called the POI. The POI listed all of the outcomes the facility hoped to measure to work towards achieving substantial compliance with this provision. The facility rated itself as being in noncompliance with every item in its self-assessment. Little information was provided as to what the facility did to make these determinations other than providing one or more of the same comments for most all of the items. The comments were: • "08/03/10-Policy and procedure is 25% complete. Additional components will be added as QA consultation contract provides processes." • "08/03/10-Data is being collected via the incident tracking log. Trend analysis is in the beginning stages with process being developed by quality services management." • "Development of CAP is contingent on analysis process that is being developed above." Given the many upcoming changes to quality assurance practices that are anticipated to occur at MSSLC over the next few months, it is hoped that the facility will engage in specific activities to self-assess the

	status of its performance for this provision and all of its components. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the self-assessment's findings of noncompliance in all areas, except that the monitoring team noted highlights regarding some quality assurance-related activities that were occurring across the facility (e.g., data collection, some graphing of data). The monitoring team's review was based upon observation, interview, and review of a sample of documents. The facility will need to do much of the same in order to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: MSSLC was not in compliance with this provision. Little activity had occurred since the baseline monitoring tour. A new director of quality assurance had been appointed and there were plans to revise the overall QA program at the facility and across the state. This included the creation of a Quality Assurance and Improvement Committee (to replace the PIC) and the contracting with an outside vendor to develop a QA program at each facility. At the time of this monitoring tour, an adequate, comprehensive quality enhancement plan did not exist. Facility-wide data were not directed to the QA department. Regular reports were not completed by the QA department for use by senior management. Even so, a number of QA-related activities continued to occur at MSSLC, including the observation and monitoring of various areas by department staff across the facility. These data were brought to PET meetings (there were three different PETs at MSSLC) and then summarized for the PIC. Other data were collected by the QA staff. Some of the data were graphed. Trend analysis data were collected at MSSLC (as was done at all facilities), however, at MSSLC the data were graphed and summarized in a manner that was useful to facility management. The monitoring team's checklist tools were being sampled and tried out by the QE staff and many other managers around the facility. Although the PIC and PETs were functioning as intended by state policy, corrective action plans were not developed correctly, and they were not tracked or managed in any organized manner. The self-advocacy group had been assigned a new facilitator, the new facility rights protection officer. It is expected that the quality enhancement program will develop and mature over the next few years at MSSLC. Improvements and developments will be needed in the breadth of the quality enhancement activities, the validity and reliability of the QA department's data collection activities, the thoroughness of the QE Plan, the use of graphic presentations, and the writing and disseminating of a regularly produced quality enhancement report. Other comments are detailed below in this section of the report.

	The monitoring team looks forward to continued development of MSSLC's quality assurance program.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	Based upon a review of documents, interviews with facility staff, and observations at the facility, MSSLC was not in compliance with this provision item. This was due to a number of factors, some of which are listed below. • A new director of quality assurance was assigned only a few months prior to the onsite tour. The new director was experienced at the facility; she had previously worked in the quality assurance department and had been the director of habilitation therapies for a number of years. Her first few months in this new position were focused primarily on learning about the job, responding to DADS regulatory activities, and learning about the Settlement Agreement. Therefore, little attention had been paid to addressing this provision item of the Settlement Agreement (and as also noted in the facility's POI for provision E). • As a result, all of the procedures and processes that were in place at the time of the baseline tour, remained in place. So, although MSSLC was not in compliance with this provision item, the many activities that were noted in the baseline report continued to occur. Therefore, there remained a solid base upon which a quality assurance program could be built to meet the requirements of this provision. • DADS was in the process of changing the overall approach of QA at the facilities to one that addressed the overall operation of the facility and incorporated all aspects of programming (as required by the Settlement Agreement and as recommended in the baseline report). The major shift was to change the PIC to a new committee called the Quality Assurance Quality Improvement Committee. This new committee and process were not yet in place at MSSLC, but were scheduled to be within the next few months. • DADS contracted with an outside vendor to develop and help implement a quality assurance system at each facility. The focus appeared to be on ICFMR regulatory compliance. The above four factors resulted in little change in the facility's QA activities. Even so, some improvements and responses to the baseline report were observed by the monitoring team and are noted in this section of the report. Other aspects, in which there was no change, are noted and the reader is referred to the baseline report where applicable. <u>Policies</u> The Director of Quality Enhancement told the monitoring team that the state policy on quality enhancement (policy #003, dated 11/13/09) was the policy used by the facility. In addition, she was completing a new/revised policy specific for the facility. As noted in	Noncompliance

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		the baseline report, the facility had many policies and the QA director should ensure that outdated QA-related policies are updated, removed, or incorporated into newer policies. Consideration should be given to having facility policy only include those aspects that are above and beyond what is in the state policy. In this way, future revisions to state policy might not require a revision to facility policy. MSSLC will need to ensure that any facility policies regarding quality assurance are in line with any state policies. Further, any facility policies related to QA should be reviewed and approved by DADS central office. <u>Quality Enhancement Plan</u> The DADS policy required the development and implementation of a quality enhancement plan (QE Plan). An adequate QE plan did not exist at MSSLC. In general, a QE plan should indicate all areas that are to be audited, the tools to be used, the frequency of audits, and the staff who are responsible for these audits. It should also describe the type of report(s) to be generated. The QA director submitted a Quality Enhancement Plan to the monitoring team, dated 8/2/10. It addressed only the provisions of the Settlement Agreement and, therefore, was inadequate as a QE Plan. That is, it did not look at comprehensive quality assurance processes, goals, and outcomes. The QE plan should incorporate all areas of quality enhancement, data collection, and information related to quality assurance and quality improvement across the entire facility. Even so, as noted below in this section of the report and in the baseline report, numerous activities were going on at the facility (e.g., data collection, observation and feedback). Some of it was collected by the QA department staff, and some of it was collected by other departments at the facility, but almost all of it was not a part of the QA program. For example, the QE plan listed out all of the provisions of the Settlement Agreement and related facility monitoring activities. All of these activities, however, were managed and reported to the Settlement Agreement Coordinator, not to the QA department. The QA department should play a role as a repository for all activities at the facility so that the information can be synthesized, summarized, analyzed, and presented to senior management in a manner that is useful for decision making and efficient and effective management of all services and supports at MSSLC. A number of comments regarding the QE plan were made in the baseline report in section E1, under the heading Quality Enhancement Plan. The comments in the baseline report remained relevant at the time of this monitoring tour. The comments addressed the following topics and are not repeated in this report:	

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		• Areas to be included in the QE plan • Specific items to be included in the QE plan • Inclusion of all QA-related activities being conducted at MSSLC • Satisfaction of individuals, families and LARs, staff, and the community • Role of the self-advocacy group • Assessing the follow-up on suggestion box items The facility presented the monitoring team with information and summary results of a DADS survey of staff that was conducted in February 2010. This was a survey of all DADS employees, not only those at MSSLC (i.e., it included office staff, those working in non-facility locations, and those working with the elderly and aging citizens of Texas). The findings indicated that the two areas of concern were internal communication and employee engagement (participation) in carrying out their work. These were broad findings that did not appear to be usable by management at MSSLC. The facility should develop its own satisfaction tools (perhaps in collaboration with the other SSLCs). The facility had implemented a monthly award for staff called Best Home of the Month. One home was nominated from each of the five units. The five were assessed based on some general criteria, such as clean, decorated, individuals seemed happy, staff seemed happy, activities were occurring, and so forth. Home Martin 3 received the award for September. This type of recognition was good to see because it can contribute to staff satisfaction. As noted in the baseline report, MSSLC had a suggestion box for staff and it was used regularly. Each week a handful of items were placed in the suggestion box and facility administration reported that they followed up on each item. This was another way of being responsive to staff input. As suggested in the baseline report, tracking of the suggestion box comments and the facility's response should be a component of the facility's QA program. In response to one of the recommendations in the baseline monitoring report, the facility attempted to create two self-advocacy groups. One had met three times, but dissolved due to lack of participation. The other group (Shamrock) was active, and had met a number of times, including during the onsite monitoring tour. The monitoring team had the opportunity to attend the meeting and then to meet with the rights officer immediately following the meeting to share suggestions. Examples of suggestions were to use the meeting as an opportunity to teach the individuals problem solving and decision-making skills. The psychology department may be able to provide some assistance in this area. The rights officer was extremely receptive to these suggestions. She was recently appointed to this position and had high expectations for this self-	

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		advocacy group to be successful. <u>QA Department</u> Colleen Range was the new head of the QA department. She was appointed to this position approximately three months prior to this onsite monitoring tour. She had worked at MSSLC for more than 30 years, most recently as the director of the habilitation therapies department. Before that, she had worked for the QA department. She was knowledgeable about the facility, but was still learning about the functioning of the QA department and the Settlement Agreement. The monitoring team met with Ms. Range and discussed quality assurance at length, including its purpose, role, challenges, and possibilities, as well as data collection topics, such as inter-rater agreement, observer bias, and observer drift, all as it related to the Settlement Agreement. The monitoring team hopes that this discussion was helpful and looks forward to the development of the department under the leadership of this new director. Etta Jenkins, the Settlement Agreement Coordinator, continued to play a large role in the QA processes at the facility. She was extremely helpful to the monitoring team, including obtaining documents, arranging for interviews, and describing facility processes. She was professional, organized, and responsive to the many requests of the monitoring team during the weeks before, during, and following the onsite tour. The QA department was part of the facility's Quality Services Management division. In addition to the director, there were three program monitors (one was recently added to the department) and a quality assurance nurse. Ms. Jenkins was part of the Settlement Agreement department and reported directly to the facility director. She had one assistant, Bobbie Hall, who was also very helpful to the monitoring team. In addition to these staff, many staff (e.g., managers, clinicians, therapists) around the facility collected data for their own departmental operations and services. Some of these data were given to the QA department, some were given to the Settlement Agreement Coordinator, and some were kept by the department for its own use. The QA department and the SAC engaged in different QA-related activities. More coordination between their work needs to occur and will, the monitoring team hopes, be addressed through the new facility-wide QAQI process. Continued professional development for quality enhancement staff was recommended in the baseline report and a number of QA staff had, or were scheduled to attend training sessions on a variety of topics. Moreover, the state central office had conducted a two-day training session for QA directors and Settlement Agreement Coordinators in May 2010. A second gathering had been cancelled, but the plan was to reschedule for sometime soon. QA staff had attended (or were scheduled to attend) trainings in root	

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		cause analysis, habilitation therapies, PNMPs, communication and language, and life safety codes. In addition, the QA director reported that she and her staff had met with QA staff from the Lufkin SSLC. This type of cross-facility communication will likely be helpful to both facilities in achieving substantial compliance with this provision of the Settlement Agreement. <u>QA Activities and Indicators</u> A number of QE activities were occurring at MSSLC. These can be grouped in three general categories of activities as listed below. • A single tool called the QA monitoring tool that looked at four areas (engagement in activities, environment, programming, and community). The monitoring team was very pleased to see that the QA director had put the past year's data into line graphs. These were easy to understand and provided a useful picture of performance by indicator and by unit. These measures were collected and managed by the QA department. • The set of tools used by all of the departments for addressing the Settlement Agreement provisions and captured via the PET meetings. For the most part these were the monitoring tools used by the monitoring team (see comments below). These measures were collected by department staff (usually managers) and managed by the Settlement Agreement Coordinator. This was the largest set of information of these three sets of measures; it included data regarding most of the provisions of the Settlement Agreement. • The trend analysis, a statewide system for reporting on four areas (unusual incidents, allegations and confirmations of abuse and neglect, injuries, and restraint usage). The facility had done a nice job of graphing these data, and incorporating useful brief narratives along with the data. Moreover, the facility had created additional graphs to further analyze (and understand) the data. These data were collected by incident management staff and managed by the Quality Services Management department head. As noted above, these three sets of data were managed by three different administrators. This was one indication of the need for a single comprehensive QA program that brings together all of the facility's data. Also, there was no special attention paid to ensuring that quality assurance activities were occurring for the four specific provisions of the Settlement Agreement that called for quality assurance or quality improvement activities (F2g, L3, T1f, and V3). In addition, there was no special attention paid to the Health Care Guidelines or Dental Guidelines by the QE department.	

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		Other areas that might be incorporated into the QA program include the following. • Set of nursing data that were regularly collected by the nursing department, especially regarding the incidence of certain disorders and illnesses. • Set of data collected and managed by the medical department, including, for example, hospital admissions and discharges, ER visits, facility admissions, sick calls, labs, x-rays, and outside referrals. • Content of PSP meetings, once this monitoring is re-initiated. • Trending of PNM-related data collected by the habilitation therapy department. • Direct care staffing levels. This deserves some special consideration. The facility collected and reported on direct care staffing in a variety of ways and management was very knowledgeable about the processes for determining required levels of staffing. Nevertheless, during the onsite tour of the facility programs the monitoring team heard repeatedly about staffing shortages and staff being pulled and reassigned from their typical assignments to other homes or programs. Therefore, there seemed to be a difference between the numbers reported and reviewed by management (e.g., only 37 vacant direct care positions out of more than 800) versus what home managers were experiencing (e.g., not having enough staff or having staff who are not familiar with the individuals). For example, during one late-afternoon observation on Whiterock 2, all of the staff were float staff and were unfamiliar with the individuals. This is an area where QA can play a role in helping the facility management address this problem. Comments made in the baseline report in section E1, under the heading QA Activities, also continued to apply at the time of this onsite monitoring tour, including those related to the reliability and validity of the QA process. The monitoring team was pleased to see that MSSLC had made some efforts to incorporate the contents of many of the tools used by members of the monitoring team. As discussed at length with the QA director, and again at the exit session during the onsite tour, please remember that these tools were designed for use by the monitoring team and, therefore, many items will need to be adapted for use by facility staff. Additional points are listed below. • The monitoring tools do not include instruction sheets or guidelines. These would need to be developed to: o Ensure that various facility staff implementing the tools were using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and o Provide adequate guidance to reviewers who did not have specific subject-matter expertise to ensure accurate rating of the tools. Again,	

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		these tools were developed by and for the use of monitoring team members with substantial subject matter knowledge. If they are going to be used by, for example, QA staff, who had more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts. • These tools should not be used to generate a cumulative score with regard to substantial compliance. The items on the tools have not been weighted, but would need to be if they were going to be used in this manner. • Some of the indicators on the tool were specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise or who engaged in specific activities during the week of the onsite monitoring tour. • At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement Agreement that calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet likely would assist in this process. <u>QA-Related Committees</u> The DADS policy required a minimal number of operating committees to be in operation at the facility. The policy listed restraint reduction, human rights, health status, incident management, behavior support committee, pharmacy and therapeutics, infection control, and skin integrity. Most of these were in operation (or were soon to be in operation, such as pharmacy and therapeutics) at MSSLC. The policy required a program improvement council; this was in place at MSSLC and is described in section E2 below. The facility held a daily Incident Management Team meeting. This was a daily meeting during which senior management reviewed the previous day's incidents, emergency restrictions, restraints, injuries, and aggression between individuals. Although this meeting was not a QA meeting, it might be used by facility administration (in addition to the PIC described in section E2 below) as a way to incorporate QA activities into the daily operation of the facility (also see section D of this report). The facility director held a weekly meeting for the senior managers at MSSLC. The monitoring team attended this meeting during the week of the onsite tour. The meeting	

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		consisted of announcements and a review from each of the managers (e.g., programs, administration, nursing, medicine, and special projects). The monitoring team appreciated the Quality Services Division director's detailed review of the trend analysis data. This was an example of how this meeting presented an excellent opportunity for senior management to review key indicators developed by the QA department. The facility director and the senior management team should consider ways that QA can inform them of other important indicators at MSSLC. The intent of this suggestion is not to duplicate what has been occurring at the PIC meetings (and what will occur when that is changed to the QAQI Council meeting), but instead to allow for more in depth review of a smaller number of key indicators, and allow for senior management to have an open discussion about those indicators. <u>QA Reports</u> The DADS policy also required performance improvement reports. These were to be self-assessments completed on a monthly basis, but there was no evidence of any type of performance improvement report.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	This provision item required the facility to analyze the data collected by the QA processes that were implemented at the facility. Based upon a review of documents, interviews with facility staff, and observations at the facility, MSSLC was not in compliance with this provision item. The facility's POI also indicated noncompliance. Further, the comments provided in the baseline report in section E2 continued to be relevant. A quality assurance report did not exist and was not in the process of being developed or created. A quality assurance report should include data, line graphs, and narrative, at a minimum. MSSLC did not have any type of quality assurance report other than the state required trend analysis of restraint usage, injuries, unusual incidents, and allegations of abuse or neglect. Even though there was not a comprehensive QA report, there were a number of data collection activities occurring at MSSLC: • The trend analysis data, as noted above, were graphed regularly over a number of years (in some cases since 2005) in a number of different formats. An interesting and useful narrative was included with most of the graphs. • The data collected using the quality assurance tool were recently put into a line graph format. Different colors were used and the data were presented by unit and by indicator area (e.g., engagement, programming). • Data collected via the PET meetings were put into a tabular format. Graphs might be useful to the PET committees, too. • The medical department had a chart called Medical Workload that included	Noncompliance

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		hospital admissions and discharges, ER visits, facility admissions, sick calls, labs, x-rays, and outside referrals). Data were in both table and pie chart format. Trending across months might be useful information for management. <u>Performance Improvement Council</u> The Performance Improvement Council (PIC) was one component of the analysis of data system as called for by the state policy on Quality Enhancement. As noted above, the meeting will be changed to have a facility-wide focus. This change was expected to occur sometime prior to the next onsite monitoring tour. The monitoring team reviewed minutes from PIC meetings, and attended a PIC meeting held during the week of the onsite tour. The group met twice each month since January 2010. It was led by the Settlement Agreement Coordinator. There was good discussion among participants at the meeting. Many important topics were reviewed, such as medication administration, engagement in activities, off campus employment, and mealtime supports. The committee also reviewed the data elements table. The PIC was also supposed to review CAPs, but as indicated elsewhere in this section of the report, CAPs were not yet an integral part of the management and QA program at MSSLC. <u>Performance Evaluation Team</u> Performance Evaluation Teams (PET) were active at MSSLC and had been active for a number of months. The facility formed three different PETs. Each PET met monthly, had different participants, and addressed a different subset of Settlement Agreement provisions. The Settlement Agreement Coordinator organized, prepared for, and ran these meetings. This made the attendance, length, and frequency of meetings manageable for facility management. The monitoring team attended a meeting for PET III. There was good discussion regarding the topics reviewed, including inter-rater comparisons for the monitoring of section T. <u>Performance Improvement Team</u> Performance Improvement Teams (PIT) did not exist at MSSLC, however, the facility had recently initiated a workgroup to look at the usage of the individual notebooks (see section V below). This might be considered to be a performance improvement team and its activities and actions incorporated into the QA program. <u>Corrective Action Plans</u> The monitoring team was given a spreadsheet document that described the status of CAPs at MSSLC. It contained three items related to pharmacy and nursing services, but it was unclear how these three items related to the many needs across all departments at	

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		the facility. That is, these appeared not to be chosen in any systematic fashion (though not unimportant). Although MSSLC did have procedures for addressing needs (e.g., incident management meetings, facility management meetings), it had not utilized a CAPs format as required by this provision and by the state quality assurance policy. This was also evident from discussions with management staff, review of documents, and observation at QA-related meetings during the week of the onsite tour. The monitoring team expects that an organized system of CAPs will be created and maintained in the future and be available for review for the next monitoring tour.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	MSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	MSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	MSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

Recommendations:

1. Implement the new QAQI process.

2. Create a facility QE plan that is functional, meaningful, and useful to MSSLC managers, administrators, and clinicians regarding Settlement Agreement provisions and other areas of service provision (e.g., ICFMR regulations). The plan also needs to include:
   - all requirements of the DADS policy on Quality Enhancement,
   - a narrative,
   - all of the areas listed on page 4 of the policy, and
   - the Health Care Guidelines and Dental Guidelines

3. Ensure that the work of the Settlement Agreement Coordinator is incorporated, and in sync with, the activities of the QA department.

4. Ensure all relevant data are submitted to the QA department from all departments at MSSSLC in a timely and complete manner.

5. Ensure validity and reliability of data collected at the facility and by the QA program.
6. Subject the QA department to quality assurance/enhancement review, feedback, and assessment.
7. Develop a satisfaction measure for individuals, staff, family members and LARs, and affiliated agencies and providers.
8. Provide program improvement reports as per the policy.
9. Develop a system to develop and manage CAPs, following all requirements of provision items E1, E2, E3, E4, and E5.
10. Develop a QA report that includes a summary of all activities, data, trends, and narrative that describes important points about the data.

The following are offered as additional suggestions to the facility:

11. Incorporate direct care staffing-related information into the QA program (e.g., vacancies, reassignments, shifts worked short staffed).
12. Follow-up, and monitor the follow-up, to items in the suggestion box.
13. Consider ways to incorporate the teaching of problem solving and decision making into the self-advocacy group meetings.

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o PSPs and PSP addendums for the following individuals • Individual #241 dated 11/5/09 • Individual #523 dated 11/2/09 • Individual #169 dated 12/9/09 • Individual #312 dated 11/4/09 • Individual #469 dated 3/24/10 • Individual #426 dated 11/17/09 (including BSP, Safety Plan, and Functional Assessment) • Individual #341 dated 2/3/10 (including BSP, Safety Plan, and Functional Assessment) • Individual #169 dated 11/13/09 • Individual #180 dated 8/16/10 (including BSP) • Individual #162 dated 12/8/09 (including BSP, Safety Plan, and Functional Assessment) • Individual #211 dated 4/7/10 (including BSP) • Individual #398 dated 4/5/10 • Individual #312 dated 11/4/09 (including BSP) • Individual #104 dated 11/30/09 • Individual #227 dated 1/11/10 • Individual #378 dated 9/15/09 • Individual #481 dated 9/30/09 • Individual #422 dated 2/3/10 • Individual #481 dated 9/30/09 (including BSP) • Individual #422 dated 2/3/10 (including BSP) • Individual #328 o PSPs and PSP addendums for 35 individuals prescribed psychotropic medications, as in section J o PST sign in sheets for: • Individual #129 • Individual #383 • Individual #232 • Individual #570 • Individual #341 o PST addendums for: • Individual #383 • Individual #129 o PFW worksheets for: • Individual #406

	• Individual #500 Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Informal interviews with individuals in various homes and day programs o Valerie McGuire, QMRP Director o Dr. Charlotte Kimmel, Psychological Services Director o Charles Brasher, Quality Services Management Director o Lloydette Harris, Human Rights Officer o Pat Samuels, Incident Management Coordinator o Lynda Mitchell, Assistant Ombudsman o Dolores Erfe, M.D., Medical Director o Victor Vines, M.D. Staff Physician o Alan LaGrone, M.D. Staff Psychiatrist Observations Conducted: o Observations at all residences o Observations at the onsite workshop, greenhouse, and active treatment classrooms o Shamrock Unit Meeting 9/14/10 o Daily Incident Management Meeting 9/14/10 o Daily Incident Management Meeting 9/15/10 o PSPA for Individual #300 9/15/10 o PSP for Individual #378 9/13/10 o PSP for Individual #37 9/16/10 o PFW meeting for Individual #406 o PFW meeting for Individual #500 o Whiterock Health Status Team meeting 9/14/10 o Human Rights Committee meeting 9/14/10
	Facility Self-Assessment: The facility was waiting on the new state policy to offer direction prior to implementation of a self assessment for section F. The facility had not completed the POI on section F, pending revision of the state policy. The policy had been revised at the time of the monitoring visit, but not yet implemented. The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and, therefore, most of the items required by this provision were either not developed or not yet implemented. As a result, noncompliance was the rating determined for most of the items in this provision.
	Summary of Monitor's Assessment: The DADS policy for this section had been revised and approved 7/30/10. The facility expected to begin

	implementation in October 2010. Most of the forms and instructions relative to PSP development had been revised either just days prior to the monitoring visit or in the weeks following the visit. Most of the PSPs reviewed for compliance with this provision were dated prior to the approved policy revision and subsequent changes in PSP format, therefore, the team was unable to assess implementation of the new policies and procedures for compliance with this provision. QMRPs were scheduled to attend training on developing person centered plans. The facility needs to ensure that the QMRPs have support from all team members and facility administrators to change the current process used to develop PSPs and that all team members understand the underlying philosophy behind the changes. The monitoring team met with the QMRP Director and some of the QMRP Supervisors during the monitoring visit. They were anticipating changes to the process of PSP development following upcoming training. The QMRP department had already implemented some changes and were trying to focus on a process that would encourage better person centered planning and bring PSP development in line with requirements of the Settlement Agreement. Quality Enhancement activities with regards to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan based on the preferences and vision of the individual. A sample of 21 Personal Support Plans (PSPs) was reviewed. Plans were essentially identical for each individual. All PSPs reviewed included two basic outcomes that were not based on the individual's stated preferences. Action steps were also similar and provided no specific information to offer guidance in carrying out the plan and providing necessary supports. Assessments that should have been used in developing plans were also not individualized for each person. There was, generally, no functional skills assessment identifying areas of need completed for individuals. Specific training objectives (SPOs) were not included in PSPs requested by the monitoring team, indicating that training was not integrated into one plan. PSPs did not describe how the individual spent his or her day, evening, or weekend and what skills were specifically being addressed in training. This clearly indicated that plans were not considered to be a comprehensive guide for staff to provide consistent supports and services to individuals. PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, psychological, psychiatric, and therapy services, along with a schedule of when these services will be provided, where they will be provided and what types of supports the individual will need throughout the day to support participation. Outcomes should reflect a plan to provide supports necessary to help each individual achieve his or her individualized vision. The overall goal of the plan should be to ensure that each individual develops or maintains skills necessary to participate to the extent possible in daily activities that are meaningful to that individual. All healthcare and behavioral risks should be identified and the team should integrate recommendations from specialists into one comprehensive plan that offers clear guidance to direct support professionals responsible for implementing the plan.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	QMRPs at the facility were responsible for facilitating PST meetings, developing, monitoring, and revising treatments, services, and supports. The facility had assigned a PSP Coordinator to each team to record information and ensure that all areas of the PSP were reviewed and discussed. Interviews with QMRPs during the review process revealed that they were generally aware of the range of supports and services being offered to the individuals whom they supported. A PSP meeting was observed for individuals #37 during the monitoring visit. The meeting was a nice example of how the QMRPs can effectively revise the PSP development process and help teams focus on individual's preferences and supports. The QMRP Assistant Director was serving as the PSP Coordinator for the meeting. She took the opportunity to gently guide the team in considering how the individual's preferences could be used to develop a meaningful plan. Work was obviously a priority for the individual, but he had been spending much of his day in bed, refusing to go to work and refusing to attend training classes. He had some medication changes over the past few months that could have been impacting his sleep pattern and stamina. The meeting started out on a negative note, when the individual showed up late having just gotten out of bed in time for the meeting at 11:00 am. Some of the team members used this as a way to chastise him for his lack of involvement in work and classroom training. Sleeping late and a lack of interest in daily activities were noted as his typical pattern. The QMRP Assistant Director used this opportunity to probe the team for possible causes and tried to model positive interaction with the individual. She gave him the opportunity to comment on his day and preferences without making negative comments about his behavior. She showed clear interest in his answers and asked leading questions to help him express his preferences. When the individual arrived at the meeting he had his head down and made very limited eye contact with the team. He was hesitant to express his opinion. When he realized that the QMRP was interested in what he had to say and was not going to be judgmental, he pulled up closer to the table and began to talk and make eye contact with team members. Occasionally, team members interjected comments about his not being able to work in the job that he chose because he had not showed up to work for his present job or demonstrated good work skills. When questioned about this, he told the team that he did not like his present job and had no interest in the	Noncompliance

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		training classes to which he was assigned. The QMRP pointed out that his present behavior in a job that he did not choose and did not like should not prohibit him from having the opportunity to try a new job. He assured the team that he would do better at the new job if given an opportunity to prove himself. A similar discussion occurred around attending training classes. He had quit going to the classes that he was not interested in but continued to actively participate in cooking classes which stated an interest in. The team agreed to discontinue the classes that he did not want to attend and replaced them with training in areas that might be of greater interest. The QMRP also recommended a medication review to see if current medication might be having a negative impact on his productivity throughout the day. The team discussed other supports that would be needed to achieve his outcomes. The individual was given a chance to direct his team meeting and consequently the plan developed was person centered and focused on helping him reach his desired goals. Another PSP meeting observed, for Individual #378, showed an attempt to focus on the individual by discussing optimal placement and developing a list of the individual's preferences. The PSP Coordinator encouraged brainstorming by the team around activities that the individual currently enjoyed. Although the team developed a fairly comprehensive list of interests, the list was not used to develop outcomes for the individual. It did not appear that plans were integrated throughout the individual's day. The person responsible for day programming discussed progress towards outcomes in the day program. Other team members were not aware of what outcomes were being implemented in the day program. As discussed in other sections of this report, it was not evident that assessments relevant to planning for each individual were being completed prior to PSP development, nor were plans consistently revised when not adequate or effective. See comments throughout this report regarding plan implementation and documentation. QMRPs should ensure that direct care staff have current information needed to support each individual safely and consistently and that all plans are being implemented as written. Current PSPs should be available to all staff responsible for plan implementation and implementation should be documented. As noted throughout section F, assessments were not completed and/or used for plan development and treatments, services and supports were not being revised as needed. The facility was found to be out of compliance with this provision item.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation	The PST annual meetings observed during the monitoring visit indicated that the PST was comprised of an interdisciplinary team based on the individual's strengths,	Noncompliance

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	Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	preferences, and needs. The individual was present at both meetings observed and staff that provided direct support to the individual were present at the meeting and given the opportunity to contribute to discussion. A review of a sample of attendance sign in sheets indicated that relevant team members were generally present at annual PST meetings with some exceptions including: • For Individual #328, the PSP did not indicate that MISD staff were in attendance at the meeting though the PSP indicated that they were the provider for educational services and recommended that the PSP and IEP objectives be coordinated. There was no evidence that input was obtained from MISD prior to PSP development. • For Individual #179, the PSP did not indicate that his LAR and MISD staff were in attendance at the meeting though the PSP indicated that MISD was the provider for educational services. There was no indication that input was obtained from MISD prior to PSP development. His MRA was also not in attendance at the meeting and did not contribute recommendations prior to development of the plan. • There was no indication that Individual #341 attended his PST meeting. • For Individual #426, there was no indication that her LAR or vocational staff attended the meeting, though work was noted as a priority for this individual. • PSP addendums for Individual #227 did not indicate that the individual had attended meetings to discuss her transition to a new home. Direct care professionals interviewed reported that they routinely attended team meetings and were given the opportunity for input into the plan both at the meeting and outside of the meeting by ongoing discussion with the QMRP regarding supports and services. There was little integration of psychiatry into the treatment planning process. Per interviews with psychology and psychiatry staff, psychiatrists were attending some treatment planning meetings. Reviews of randomly selected PSP sign in sheets did not reveal signatures of the psychiatric physicians indicating attendance. When key members of the PST are unable to attend meetings, it is suggested that the team documents any attempts to get input before the meeting and include recommendations from the team member not attending the individual's PSP. The facility was rated as being in noncompliance with this provision item.	
F1c	Conduct comprehensive	Limited assessments were performed prior to PSP development. Brief summaries of	Noncompliance

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	assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	those assessments were included in the PSP narrative. It was not evident that relevant assessments based on each individual's needs and preferences had been considered prior to PSP development. For example: • Individual #162's PSP noted that an OT/PT assessment had been completed though there was no indication that this was a priority need for him, however, the PSP did not reference information from a functional skills assessment or vocational assessment. • There was no evidence that a functional skills assessment had been completed prior to PSP development for most individuals reviewed. • A PSP addendum for Individual #383 indicated that the team met to discuss hip pain. There was no indication that assessments had been ordered to address the hip pain and no recommendations were made other than PRN pain medication and to watch for side effects associated with the medication. As noted in a number of other sections in this report, the monitoring team found the quality of some assessments to be an area of needed improvement. In order for adequate protections, supports, and services to be included in individual's PSPs, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed. Information from assessments should be included in the PSP body and used to develop supports based on the individual's preferences and needs.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As noted in section F1c, it was not evident that assessments were updated as needed or that results were used to develop, implement, or revise PSP supports. The PSP included information from specific disciplines in isolated sections of the PSP, rather than integrating assessment information into one plan that staff could use to support the individual. For this reason, this provision item was rated as being in noncompliance.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	Community placement was discussed at most PST meetings according to the PSP, though the discussion was limited and little action was taken to move forward with community placement. PSPs indicated that individuals and their LARs were provided with information regarding community placement, if requested. Nearly all PSPs reviewed concluded that current placement was appropriate without any real discussion around removing barriers to living in a less restrictive environment. Individual #241's team had taken step towards community placement. Community living options were discussed at his annual PST meeting on 11/5/09 and it was determined that community placement was appropriate. The team developed a list of supports that would be needed in the community, though not a comprehensive list, it was a good starting place. The team met again on 7/20/10 after identifying providers in the community to discuss options and plan for transition into the community. On 8/11/10, a	Noncompliance

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		community group home visit was arranged for Individual #241. Other PSPs reviewed indicated that this type of planning was not occurring for all individuals at the facility. For example: • The PSP for Individual #341 indicated that his parents wanted their son to remain at MSSLC due to concerns that his needs could not be met in a community setting based on a past unsuccessful placement. The team justified continued placement based on the parent's recommendation without developing strategies to address the parents' concerns. It was noted that the team would provide additional information on community placement if requested by the parents. There was discussion around the most appropriate placement for the Individual based on his needs. • The PSP for Individual #523 indicated that he was interested in community living and did not address any barriers to living in the community. The team did not make any recommendations for community placement. There was generally no consideration of community-based day programs or supported employment by the team. Although trips were planned in the community each week, active treatment did not focus on functional learning in the community and outcomes in individual PSPs did not focus on training in the community. Observation at the sheltered workshop on campus indicated that there were many individuals who had valuable job skills that would transfer well into a more integrated setting. There were job opportunities available at the facility and several individuals worked outside of the sheltered workshop, but there was little indication that employment outside of the facility had been considered for most individuals. Vocational assessments were not discussed in PSPs even for those individuals that indicated work was a priority. The facility was rated as being in noncompliance with this provision item.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:	This monitoring team looks forward to reviewing this provision once there is implementation of newly developed state policies to address PSP development and implementation.	
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two		

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	years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	Every PSP reviewed had the outcome, "Attain best possible health" and typically one other that either stated "Live in a less restrictive environment" or "Participate in activities of daily living." Outcomes were not based on stated preferences for each individual. All plans included a list of individual's preferences. Some were very specific, for example, • Individual #523's PSP noted that he enjoyed dismantling objects of interest, playing the keyboard and drums, working and earning money, and watching movies. • Individual #341's PSP noted that he enjoyed bicycling, basketball, Frisbees, train and bus rides, fishing, going to the gym, putt-putt, finger foods, and ice cream. These lists, however, were not used to develop outcomes for either individual. The PSPs that were reviewed typically had an action step under the outcome "participate in daily activities" for "social/leisure activities both on and off campus." Plans did not state functional learning that would take place while the individual was in the community or even what activity the individual might participate in. Teams should use "what's most important to the person?" section of the PSP to list specific things that are important for the individual and then develop outcomes and include supports that the individual needs to maintain or increase the occurrence of those things in his or her life and address any barriers to occurrence. Moreover, the Personal Focus Worksheet process also provided valuable information regarding individual's preferences that might be used in the PSP process (as well as in the obtaining of individual satisfaction information as described in section E). The facility was rated as being in noncompliance with this provision item.	Noncompliance
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet	As discussed in the F1c above, outcomes were rarely related to the individual's preferences and vision. Outcomes did not contain enough information to be observable and measurable and, as noted above, plans were not consistent in addressing supports needed to achieve outcomes. For example, • The PSP for Individual #179 did not include specific objectives related to his stated preferences. • The PSP for Individual #426 listed working and earning money as something most important to the individual. There was no discussion around employment	Noncompliance

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	needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	in the PSP and outcomes were not developed to address employment. • Action steps in most PSPs were identical for each individual and too vague for staff to use them as a guide for supports. All action steps should include information that would direct staff in how to implement the action step consistently and to determine what level of participation by the individual is needed to successfully complete each step. The facility was rated as being in noncompliance with this provision item.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted throughout this report, many recommendations from assessments were not integrated into outcomes and strategies to support individuals throughout their day. Treatment plans and clinical care plans were often stand alone documents that were not integrated into an overall plan. For Individual #179 and Individual #378, the PSPs recommended that the IEP objectives be coordinated with the PSP in as many areas as possible to foster better coordination of services. There was no evidence that the team discussed the IEP objectives at the PSP meeting or integrated them into the PSP. This was found to be the case with all individuals who attended school. Risk for individuals was not consistently addressed throughout the PSP to ensure that staff knew how to provide safe supports for each individual. See section I of this report for specific examples. When developing the PSP for an individual, the team should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. It is expected that implementation of new state policies and training on person centered planning will guide QMRPs in developing meaningful plans. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Plans designated staff responsible for implementation of the objectives by discipline, but lacked specific methods for implementing outcomes as discussed in F2a2 above. Target dates for completing objectives were not included in most plans reviewed. The team should assign completion dates that correspond with the individual's rate of	Noncompliance

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		learning and develop a set of next step objectives that will move the individual closer to his or her long-range goal. Specific training strategies should be included in the PSP. The facility was rated as being in noncompliance with this provision item.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	As noted in previous sections, a majority of outcomes in the PSPs reviewed did not adequately address supports needed by the individual to achieve outcomes and did not consider what the individual would need to learn to become more independent in the community. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	The plan specified how data would be collected, but not what data would be collected for each outcome. A discipline was named as responsible for each outcome, but was not specific in terms of who would actually collect that data and who would review the data. The facility was rated as being in noncompliance with this provision item.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	The monitoring team found a lack of coordinated supports and services throughout the facility. Although team members from various disciplines met together to develop the PSP, it was not evident that supports were integrated into one plan. The facility did not have a process to ensure coordination of all components of the PSP. See comments throughout this report regarding the lack of integration of services for individuals. The facility was rated as being in noncompliance with this provision item.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	As noted throughout this report, PSPs did not offer staff clear guidance on providing a range of supports to each individual to ensure training was consistently implemented and the individual would remain safe and healthy. The facility was rated as being in noncompliance with this provision item.	Noncompliance

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F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	A review of records indicated that the PST routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues. These meetings were often just a discussion of events. It was not evident that assessments were updated or that PSPs were modified to address changes in intervention or support strategies. For example, Individual #169's PST had met at least 19 times in 2010 to review a number of incidents and changes in status, including 27 injuries since January 2010 and an increase in fall incidents. Direct care staff had reported increased unsteadiness, particularly following morning medication administration. Although the team had increased his supervision to one-to-one, there was no indication that his PT evaluation had been updated to include recommendations for increased support or that his medication had been reviewed by the PCP. It was also not evident that teams met when there was lack of progress towards PSP outcomes or when outcomes were completed. Few of the PSPs reviewed had been modified outside of the annual PSP meeting, though data collection indicated that individuals had completed outcomes or had made no progress at all on outcomes during the year. QMRPs should monitor plan implementation for progress and convene the team to address barriers when progress is not being made. The facility was rated as being in noncompliance with this provision item.	Noncompliance
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-	As noted above, staff responsible for developing plans will need to be trained on new policies relating to PSP development. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised. There was no system in place to ensure that this occurred and there was no documentation in place to show that staff had been trained on individual plans initially or when they were updated or modified. During interviews, direct care professionals indicated that they were often pulled to work in different homes. Staff reported that they received an overview of support needs for each person in the home, but were able to work with individuals without having competency based training on the needs of individuals in that home. For example, pulled staff that did not routinely work with an individual did not typically have competency based training on supports such as transferring or repositioning for individuals they were assigned to support according to staff interviewed. This provision of the Settlement Agreement will continue to be reviewed in upcoming monitoring visits to determine the adequacy of training in providing team members with the skills to develop and implement comprehensive, effective plans for individuals.	Noncompliance

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	based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	The facility was rated as being in noncompliance with this provision item.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	A sample of new admissions was not reviewed during this monitoring visit. All PSPs in the sample reviewed had been developed within the past 365 days. As noted in F2a, plans were not revised when objectives were met or no progress was being made. There was evidence that PSTs met when significant events occurred throughout the year, but plans and supports were not typically revised when this occurred as noted throughout section F. The facility was rated as being in noncompliance with this provision item.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Quality enhancement activities with regards to PSPs were in the initial stages of development and implementation (also see section E above). As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan. The facility had implemented a new QA process and noted the following on the POI: "SAMTs are being used by the QMRP Department, as well as the QA Department in this area. Trending and tracking are in initial stages and data is felt to be unreliable at this time due to changes in the monitoring tool from the QSO monitoring tool to the current SAMT. Interpretations by those monitoring have been inconsistent, but are coming more in alignment as methods of monitoring are changing. For example, discussions with the PCC indicate that our QA monitoring was not true QA, but was instead a separate monitoring and the QMRP and QA Departments have collaborated on ways to get more consistent results." A sample of four monitoring tools completed by QMRPs was reviewed. The tool used was the monitoring team's monitoring instrument for this section of the Settlement Agreement. It was noted that the QMRPs reviewed services and supports in place, but not necessarily the adequacy of those services and supports. This was a good starting point for self-evaluation; hopefully, the facility will learn from this process and revise the	Noncompliance

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		process and monitoring tool to meet their specific needs.	

Recommendations:

1. Conduct comprehensive assessments that identify the individual's preferences, strengths, and supports needed.
2. Develop a system to ensure all staff receive competency based training on providing supports to individuals as outlined in their PSP.
3. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed.
4. PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, and therapy services, along with a schedule of when these services will be provided, where they will be provided and what types of supports the individual will need throughout the day to support participation.
5. All action steps should include information that would direct staff in how to implement the action step consistently and to determine what level of participation by the individual is needed to successfully complete each step.
6. The team should assign completion dates that correspond with the individual's rate of learning and develop a set of next step objectives that will move the individual closer to his or her long-range goal.
7. Ensure that outcomes are consistently implemented and progress is documented and reviewed.
8. Develop a system to monitor the PSP, the implementation of services and supports, and the timely modification of plans when services and supports are not effective.
9. Implement a quality assurance process for assessing whether PSPs are developed consistent with this provision.
10. Integrate psychiatry into the treatment planning process.
11. Include information regarding the individual's psychotropic medication regimen in the PSP. This information should be documented in collaboration between psychology and psychiatry to ensure the accuracy of information promulgated.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Table of contents/outline of MSSLC policy and procedure manuals: Brown: organizational, Green: campus, and Blue: home life and training o MSSLC POI, updated 8/26/10 o MSSLC POI Supplement, 8/18/10 o MSSLC Section G and H Settlement Agreement Presentation Book o Summary sheet from opening presentation made to the monitoring team, 9/13/10 o Organizational chart, dated 8/18/10 o PIC meeting minutes: 1/5/10 through 9/15/10 (15 meetings) o Medical workload data for August 2010 o List of typical meetings that occurred at MSSLC o List of meetings at MSSLC for week of 9/13/10 o MSSLC Forensic Plan, 7/21/10 o List of clinical positions, staff and consultants o Staffing vacancies as of 9/13/10 Interviews and Meetings Held: o Dr. William Lowry, Facility Director o Dr. Delores Erfe, M.D., medical director o Brenda Shoemake, Assistant Director of Programs o Director of Psychology o Facility psychiatrists o Residential Unit Directors: Polly Bumpers, Bertha Allen o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite tour. Observations Conducted: o Presentation made to monitoring team by senior staff at MSSLC at opening meeting o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Many residences, day program, and vocational program o Facility senior management meeting, 9/14/10 o PIC Meeting, 9/15/10 o Psychiatry clinics

	Facility Self-Assessment: The facility's self-assessment was called the POI. It listed all of the outcomes the facility hoped to engage in and measure to work towards achieving substantial compliance with this provision. The facility rated itself as being in noncompliance with every item in its self-assessment. Even so, many of the items had information in the comments section that provided the monitoring team with some details about what the facility had done, and what it planned to do. A majority of the items were newly initiated (i.e., reported as recently occurring as of 8/3/10), but taken as a whole, indicated that MSSLC was working towards the type of integration of clinical services that is the intent of this provision. Some of the comments, however, merely listed scores on monitoring tools used by other departments (e.g., nursing, pharmacy) and, therefore, it was not evident as to how this information related to integration of services. On the other hand, some comments indicated that clinicians were communicating and working together (see list in G1 below).
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite tour to address this provision of the Settlement Agreement. The facility had identified the medical director as the lead manager for this provision of the Settlement Agreement, and some activity had occurred regarding this provision item since the baseline tour. Clinicians across the facility were becoming familiar with this provision. A number of examples of ways in which MSSLC was working towards a greater integration of clinical services, as well as examples of areas in which integration was not occurring, are presented below. The importance of the provision of integrated services was acknowledged by facility management and clinicians. Moreover, there was an interest and desire to have this occur.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they	A plan was not in place to address this item, policies and procedures did not exist, and there was an absence of integrated clinical services. Even so, the facility had made progress in this area as demonstrated by examples of new activities towards integration of clinical services. More work needed to be done, as acknowledged by the facility and described below. Consequently, this provision item is rated as being in noncompliance. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision. Clinical staff at MSSLC were aware of this provision of the Settlement Agreement; the medical director had been assigned lead responsibility for this provision, and some	Noncompliance

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	need.	actions had occurred towards addressing this provision. Dr. Erfe described facility activities towards meeting the requirements of both section G and H and noted that they were in early development. She described the items listed below. • A daily doctors meeting was occurring that included the hospital liaison nurse. • PCPs were more aware of need to share the neurology consultation notes with the psychiatrists; this was being done during the daily doctors meeting. • New monitoring tools were being used. • Monitoring tools completed by psychiatry, PCP, nursing, and habilitation indicated whether there were comments in the IPN. • Physicians and psychiatrists were doing monitoring of records to see whether integration was occurring (but it was not clear to the monitoring team as to what criteria they were using). • Speech pathology was assigned to assess each individual's risk for aspiration/choking, instead of nursing. • A new electronic format was being adopted so that clinicians reviewing for certain areas (e.g., diabetes, pneumonia) could indicate their determination of level of risk. The POI described other ways in which the facility was working towards the provision of integrated clinical services: • Primary Care Physicians (PCP) and Psychiatrists were continuing to utilize the Integrated Progress Notes. • Physicians were not always able to be in attendance at all meetings to discuss BSPs, however, attendance was improving. • An electronic Integrated Progress Note was generated every weekday, except holidays. The note was posted for the PST to view and information was reported at the daily incident management meeting. • Medical and pharmacy: The pharmacist was to contact the PCP when there were problems with a medication order. These communications were to be recorded in the Pharmacy Clinical Intervention Report. • Nursing: Nurses received educational training on Assessments and Care Plans. • Psychiatry and pharmacy: Psychiatrists were reviewing the psychotropic drug regimens at each quarterly psychiatric medication review and each quarterly drug regimen review. • PCP and Psychiatrists had been advised to document medication changes. • Psychology: Staff were to receive training on documenting the integration of the BSP and psychology services across other disciplines. • PNM: Physical therapists were assigned to attend the Nutritional Management	

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		Team meetings. • OTPT: Not yet completed due to staff shortage. • Communication: Not yet completed due to staff shortage. And some examples were observed by the monitoring team: • When there were significant changes in an individual's health status and needs, in general, there were timely meetings of the individual's PST to review, discuss, and discern what changes, if any, were needed in the individual's PSP and/or HMP. • As discussed in the psychiatry section of this monitoring report (section J), there were attempts to integrate clinical services at the facility. Psychiatric physicians were well integrated with the primary care physicians, and there were modalities to ensure that some information, especially emergent information, was transmitted. • There were beginnings of integration between psychiatry and psychology. Psychiatrists were attending Behavior Therapy Committee meeting and were active in some treatment planning. • The new PNMT process was a positive step toward improved integration of clinical services in that OTs, PTs, SLPs, RDs, and RNs worked together to complete comprehensive assessments and to engage in clinical problem-solving to ensure appropriate interventions that can be measured to ensure efficacy and positive outcomes for individuals who were at highest risk. Other examples indicated that more work needed to be done • There was need for better communication between campus administrators and clinical/medical staff. For example, numerous examples were provided where physician questions, requests, suggestions, or orders were denied with little or no discussion from campus coordinators (e.g., ordering of a helmet, use of positive reinforcement, individual refusals to go to day programming, vehicles and transportation). • Communication and collaboration between medical services and pharmacy services was lacking. The daily physician meetings included the hospital liaison nurse, but there was no other daily forum for exchange of information between medical, nursing, psychology, and pharmacy services. A lack of onsite neurology services resulted in the absence of neurology-psychiatry integration that is essential for the population of individuals being served. • During annual PST/PSP meetings, there was no evidence that the individuals' nurses provided a comprehensive overview of the individuals' health status, needs, and risks, and/or summary of their response to treatment interventions and their progress/lack of progress toward achievement of their desired health	

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		outcomes. • Oftentimes, the nursing section of the PSP referred the reader to "See Nursing Assessment," which did not provide an adequate recapitulation of the individual's health over the past year. • There were challenges noted with respect to the transmission of neurological consultation information. The facility did not have an onsite consultation clinic. Individuals had to travel two hours in order to see a neurologist. As such, consultation information was transferred via the primary care physician to the psychiatrist. • Some of the involvement in the team process was physician-specific, that is, one particular physician attended the majority of these integrative team meetings. Unfortunately, this particular physician tendered his resignation during the monitoring tour. • The facility psychology staff were not producing useful data for the psychiatrists to base decisions regarding medication adjustments. While some graphs were being created, there were issues with the addition of medication adjustment information and sentinel events (e.g., social stressors) that were not included on the graph. • There was a need for collaborative case formulation and diagnostics, as well as for the collaborative development of a behavioral/psychopharmacological treatment hypothesis. • Psychologists reported that they could not use interventions that would result in more effective treatment outcomes (see K9) • There was an absence of necessary data provided in psychiatric clinics for psychiatrists to make data based medication decisions (see K4) • Psychologists reported that direct care staff often did not collect data reliably (see K4) and were not made readily available for training on PBSPs. • The lack of meaningful integration of clinical services was evident in the absence of skill acquisition plans targeting communication and language programming. • There was little collaboration between psychology and speech and language pathologists. The only tool was the Communication Dictionary, but there was little to link those with the BSPs, and integration of strategies was inconsistent between these two plans. • Habilitation Therapies did not attend PST meetings, either annually or special interim meetings, related to significant events or changes in an individual's status, including hospitalizations and choking incidents. There was unanimity in a desire to work towards and achieve an integration of clinical services, including more communication, acceptance of input and opinion from all clinical disciplines, and notification of treatment changes to all relevant clinicians.	

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		Achieving integration will be a facility-wide process, that is, it will require that all departments and all levels of staff participate. Under the leadership of the facility director, MSSLC should address the need for integration of clinical services. Modifications to the PIC meeting into the QAQI Council may contribute to setting the occasion for this integration to occur.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	A plan had very recently been put into place to address this provision item. Dr. Erfe and the POI indicated that the PCP documented all consultation reports in the IPN and, further, had been advised to state whether they agreed or disagreed with the recommendations. If the physician disagreed, he or she was to document the reasons why. If the physician agreed, a physician's order was to be written addressing the recommendations. The RN Case Manager was to inform the QMRP if a PSP meeting was necessary. The monitoring team also observed that primary care physicians reviewed outside non-facility consultations. The records contained evidence that recommendations were noted and either adopted or not adopted. It was not always evident that those decisions were discussed at the team level. Non-facility consultations and recommendations were reported to be primarily from Scott & White Hospital, and secondarily from local specialists. A consultation triplicate form was typically filled out along with a dictated/written consult note. The process at MSSLC was for the nurse to pull the record and give it to the physician. The physician then added any additional findings or impressions, and whether or not he or she agreed, as noted above. Dr. Erfe reported that it was very rare for a PCP to disagree with the non-facility recommendations. She noted that the entering of consultation information by the PCP into the IPN had been going on for a while at MSSLC, but that the addition of comments regarding agreement/disagreement was new. Further, the Hospital Liaison nurse was directly involved in the daily process of reviewing non-facility clinician's recommendations. There was evidence, however, that RNs failed to timely review non-facility clinician's reports and recommendations and ensure that the clinician's recommendations were addressed and implemented in a timely manner. One of the most common examples of this was failure to ensure timely follow-up to podiatrist's recommendations and/or clinical therapists' recommendations for changes in rehabilitation/restorative plans and programs.	Noncompliance

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		It appeared that a dedicated fax machine would be beneficial to meeting this provision item. The medical clerk received all physician orders and results for these outside non-facility consultations, but it was often difficult to manage (i.e., not lose) these faxes given that the current single fax machine also received a lot of other faxed information from other facility operations. Thus, MSSLC had made progress towards meeting this provision item and it is likely that it will be found to be in substantial compliance during the next monitoring team visit.	

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.

The following are offered as additional suggestions to the facility:

3. Consider examining each of the two provision items listed above in this section of the report regarding areas indicating where work needed to be done to address the integration of clinical service provision.

4. Provide a dedicated fax machine to the medical clerk.

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Table of contents/outline of MSSLC policy and procedure manuals: Brown: organizational, Green: campus, and Blue: home life and training o MSSLC POI, updated 8/26/10 o MSSLC POI Supplement, 8/18/10 o MSSLC Section G and H Settlement Agreement Presentation Book o Summary sheet from opening presentation made to the monitoring team, 9/13/10 o Organizational chart, dated 8/18/10 o PIC meeting minutes: 1/5/10 through 9/15/10 (15 meetings) o Medical workload data for August 2010 o List of typical meetings that occurred at MSSLC o List of meetings at MSSLC for week of 9/13/10 o MSSLC Forensic Plan, 7/21/10 o List of clinical positions, staff and consultants o Staffing vacancies as of 9/13/10 o Review of records of 35 individuals prescribed psychotropic medication (see section J) Interviews and Meetings Held: o Dr. William Lowry, Facility Director o Dr. Delores Erfe, M.D., medical director o Brenda Shoemake, Assistant Director of Programs o Director of Psychology o Facility psychiatrists o Residential Unit Directors: Polly Bumpers, Bertha Allen o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite tour. Observations Conducted: o Presentation made to monitoring team by senior staff at MSSLC at opening meeting o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Many residences, day program, and vocational program o Facility senior management meeting, 9/14/10 o PIC Meeting, 9/15/10 o Psychiatry clinics

	Facility Self-Assessment: The facility's self-assessment was called the POI. It listed all of the outcomes the facility hoped to engage in and measure to work towards achieving substantial compliance with this provision. The facility rated itself as being in noncompliance with every item in its self-assessment of this provision. Even so, many of the items had information in the comments section that provided the monitoring team with some details about what the facility had done, and what it planned to do. A majority of the items were newly initiated (i.e., reported as recently occurring as of 8/3/10), but taken as a whole, indicated that MSSLC was working towards meeting the intent of this provision.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite tour to address this provision of the Settlement Agreement. Even so, some activities were occurring at MSSLC. Similar to section G described above, medical and clinical staff were beginning to work towards meeting what they considered to be the criteria of this provision further highlighting the need for state policy to provide guidance and direction to the facility. Across the facility, there was great desire for coordinated clinical treatment, and to have that treatment contain more than just the minimum generally accepted professional standards of care as set forth in this provision.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	A plan was not in place to address this provision item and the facility did not have any procedures in place to ensure assessments and evaluations were completed on a regular basis and in response to developments or changes in an individual's status. This was also acknowledged in the facility's POI for this provision item; it was rated as being in noncompliance. MSSLC, however, had made progress towards meeting this provision item. The medical director said that a new procedure had been put in place whereby physicians were given a list of annual assessments that needed to be completed that month, as well as a list of any assessments that were past due from the previous month. She also noted that PCPs and psychiatrists were now documenting in the IPN their responses to the recommendations made by the pharmacists in the QDRRs. More work, however, needed to be done in order for this provision item to come into substantial compliance. For example, medical staff performed evaluations on sick call	Noncompliance

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		based on acute medical problems and the need for follow-up. Follow-up of acute medical problems and post-hospitalization evaluations were inconsistent and at times inadequate. Primary care physicians did not complete quarterly assessments. Current annual and/or quarterly nursing assessments were not present in 10 of the 30 records reviewed. The monitoring team reported this finding to the facility, who responded with the submission of several additional documents to address this issue. Thus, as of the time of submission of this report, there were current annual and/or quarterly nursing assessments for 22 (73%) of the 30 records reviewed. One of the 22 (Individual #212), however, contained a six-month time period (9/09 to 3/10) where no nursing assessments were completed. Of the 30 records reviewed, most of the nursing assessments were not complete or comprehensive. As discussed in the psychiatry section J of this report, the facility had been completing annual psychiatric evaluations, however, these were variable in regard to completeness, specifically with regard to the case formulation and treatment planning and recommendations. This was an area that could be amenable to increased collaboration with psychology for the creation of a diagnostic formulation. It was also an area that could be impacted via quality assurance or peer review processes. The facility's functional assessments (see section K5), PBSPs (see K9), and psychological assessments (see K5, K6, and K7) were not consistent with generally accepted professional standards of care. There was little evidence of the change over time noted in the Habilitation Therapies documentation. The annual assessment reported current status, but little was described about supports provided over the previous year, the effectiveness of those plans, and sound clinical analysis to justify ongoing supports and services, modification to a plan, or discontinuing them for the upcoming year, particularly in the OT/PT evaluations.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and	There was no policy in place to require or guide the activities required to meet this provision item. MSSLC, however, had made some progress. SOAP documentation format was being used and a psychiatric master bill was in place that was used by all psychiatrists and on which they indicated the diagnosis. Nevertheless, as per a review of psychiatric evaluations, monthly medication reviews, and quarterly medication reviews, there were no diagnostic formulations outlining the specific symptoms that individuals were experiencing that met criteria for a specific diagnosis. For additional information regarding this issue, please refer to the discussion	Noncompliance

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	Related Health Problems.	of provision J8. Often, nursing assessments failed to result in a complete or accurate list of nursing diagnoses, in accordance with NANDA.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	MSSLC did not have a plan procedure in place to ensure that treatments and interventions were implemented timely and were clinically appropriate. The medical staff conducted sick call daily to address new issues, acute medical issues and follow-up. Follow-up of clinical conditions and diagnostics as detailed in Section L was often not adequate. It was also evident that physicians were not reassessing risk levels after major changes in clinical status. MSSLC is in dire need of review and revision of its process of identifying "Service Objectives" (i.e., goals/outcomes related to health). There were many examples of HMP service objectives that failed to reveal that individuals' desired outcomes were appropriately considered and/or incorporated into the process. Some of these service objectives were not consistent with ensuring individuals' health and safety and protection from harm. For example, one individual's HMP goal was to experience "less than eight (8) episodes of complications of HIV (emphasis added)," rather than to be free of complications of HIV, as recommended by his PST. Another individual's HMP goal was "will experience 12 or less episodes of alteration in skin integrity (emphasis added)." Another individual's service objective related to seizure was that she "will experience 12 seizures or less during the next 12 months;" the service objective related to constipation was that she "will experience less than 10 episodes of constipation during the next 12 months;" and the service objective related to GERD was that she "will experience less than 3 complications of GERD during the next 12 months." It is strongly recommended that this individual's clinical professionals review and revise these objectives, especially since any one of these complications is not a desired health outcome and not without serious consequences and complications, including death. As it was difficult to determine the accuracy of diagnoses, it was also difficult to determine the appropriateness of medication. A review of the records revealed medications prescribed for indications that were not described as specific target symptoms, that were not being monitored by psychology as data points, and that were not in concert with the proposed diagnosis. For additional information, please see the discussion regarding provision items J13 and J9. Examples are described in this report, including regarding changes in psychiatry treatment (Section J), updates and modifications to PBSPs based upon the functional assessment and/or a lack of progress (Section K), and changes in risk status based upon	Noncompliance

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		occurrences of medical-related events (Sections I, M, and O).	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	Neither a plan nor activities were in place to address this across the variety of clinical disciplines at the facility. The facility did not have a way of determining if appropriate clinical indicators of efficacy of treatments were being used across all disciplines. Consequently, this provision item was rated as being in noncompliance. The medical director also acknowledged the need for the clinical departments to improve documentation of indicators, in part to a criterion that someone who will review the chart and doesn't know patient and history will understand it. Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and NCPs were not revised, and they did not reflect the most current conditions and intervention strategies. Therapists did not conduct proactive reviews of interventions plans such as the Dining Plan or PNMP, but rather waited for a referral from the physician, PST or problem identified by PNMPCs. In some cases PNMPs were not consistently updated following a change in status. Some examples were cited in sections O, P, and R below. There were, generally, no measurable goals established for interventions provided. Documentation was more anecdotal in nature, making it difficult to track progress and compare data to determine progress over time. The facility and state should be sure to address clinical indicators for all areas of clinical practice, not only in medical care and nursing services.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	A plan was not in place to address this item and, therefore, this item was rated as being in noncompliance. The medical director, however, described some activities that were in place to begin to address this provision item. These included quarterly psychiatry reviews and QDRRs. The Health Status Team was operating and reviewing each individual every six months, but, as noted elsewhere in this report, the HST did not look at all aspects of health (it looked primarily at risk) and had numerous problems as indicated in other sections of this report.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with	Neither a plan nor activities were in place to address this item and without clinical indicators identified (see H4 above), treatments and interventions cannot be modified in	Noncompliance

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	full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	response to clinical indicators. The facility, however, was beginning to attend to this provision item. Examples were provided during discussions with the medical director regarding ways treatment might change based upon indicators, such as modifying treatment of a scratch that became swollen and would then need antibiotics, and if a cold became a pneumonia. Across all 30 individuals reviewed in section M, however, the HMPs did not consistently address all of the health care needs of the individuals; and NCPs were not consistently prepared in a timely manner, or at all, in response to individuals' acute and/or emergent health care problems and risks. Some of the 30 individuals reviewed had "mini" medical disorders addressed with a "stock" care plans. These "mini-plans" included such plans as the Asthma Plan, Allergic Rhinitis Plan, Dry Skin Plan, Constipation Plan, GERD Plan, Seizure Plan, Anemia Plan, Osteoporosis Plan, Diabetes Plan, Parkinson's Disease Plan, and Hyperlipidemia Plan. Although the medical disorder care plans appeared to be added to the individuals' HMPs to provide additional direction and guidance to caregivers, these plans were not specific enough for caregivers to be able to pick it up and effectively continue the care. The medical disorder care plans had not been adequately customized and/or personalized to address individuals' specific health problems and risks. Rather, they referenced generic interventions mostly related to "monitoring" and "reporting" activities and usually instructed the reader to follow other "plans" e.g., "See HMP," "Per "Follow BMP," "Maintain per PNMP," "See physician's orders," etc. Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and NCPs were not revised, and they did not reflect the most current conditions and intervention strategies. There was no evidence that, at least quarterly, individuals' nurses conducted a comprehensive review of the individuals' HMPs and current NCPs to ensure that the plans continued to be appropriate and relevant to the individuals' health status.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the	Policies, procedures, and guidelines were not in place regarding Section H and, therefore, this provision item was found to be in noncompliance. Facility management also acknowledged that this provision item was not yet being addressed. The state had issued policies to guide the provision of medical and dental services (DADS	Noncompliance

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	provisions of Section H.	policy #009: Medical Care, and DADS policy #015: Dental Services). The MSSLC medical department had not issued any facility protocols or facility guidelines for medical management based on the state issued policies. The dental clinic had not implemented the state issued policies.	

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not minimum common elements of clinical care are being provided to individuals. This will require defining minimum common elements of clinical care, creating measurable actions, and monitoring measurable outcomes.

3. Improve the way HMP objectives are determined and written as described above in section H3.

The following are offered as additional suggestions to the facility:

4. Do not use mini-plans if they cannot be individualized in a manner that provides appropriate treatment to the individual.

5. Consider an electronic medical record; this may be an effective way to implement clinical indicators and provide for accurate tracking.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #006: At Risk Individuals o DADS Risk Assessment Tools, dated 8/31/09 o List of individuals requiring sutures/dermabond 1/1/10-6/30/10 o List of Risk Level for all individuals at the facility o List of individuals hospitalized since 1/1/10 o List of individuals seen in the ER since 1/1/10 o List of 10 individuals with the most injuries since 1/1/10 o List of 10 individuals causing the most injuries to peers since 1/1/10 o List of injuries resulting from slips, trips, or falls since 1/1/10 o List of all injuries since 1/1/10 o PSPs for the following individuals • Individual #227, Individual #422, Individual #211, Individual #523, Individual #378, Individual #506, Individual #481, Individual #469, Individual #169, Individual #241, Individual #104, Individual #179, Individual #328, Individual #225, Individual #219, and Individual #36 o Health Risk Assessments reviewed by the HST since 1/1/10 Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs; o Charlotte Kimmel, PhD, Director of Psychology o Valerie McGuire, QMRP Director o Dolores Erfe, M.D., Medical Director o Victor Vines, M.D. Staff Physician o Alan LaGrone, M.D. Staff Psychiatrist Observations Conducted: o Observations at all residences o Observations at the onsite workshop, greenhouse, and active treatment classrooms o Shamrock Unit Meeting 9/14/10 o Daily Incident Management Meeting 9/14/10 o Daily Incident Management Meeting 9/15/10 o PSPA for Individual #300 9/15/10 o PSP for Individual #378 9/13/10 o PSP for Individual #37 9/16/10 o Whiterock Health Status Team meeting 9/14/10 o Human Rights Committee meeting 9/14/10

	o Restraint Reduction Committee meeting 9/16/10
	Facility Self-Assessment: The facility POI indicated that the facility was not in compliance with most provisions of section I. There had been a focus on infection control and immunizations to address recommendations from the last monitoring visit. The POI indicated that the facility had made some attempts to identify individuals at risk and were continuing to look at ways to ensure that information was accurate and staff were trained on risk for each individual. The monitoring team agreed with most of the findings in the facility's POI for this provision.
	Summary of Monitor's Assessment: State Policy #006: At Risk Individuals had been developed by the state to address assessing risks for individuals. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. The rating forms allowed individuals who were at risk to be rated low if plans were in place to address specific risk. This practice continued to be a concern to the monitoring team because it did not alert staff that individuals at risk needed to be monitored more frequently for signs and symptoms of risk. The other concern of the monitoring team regarding risk ratings was that plans addressing risk were often not sufficient or were not monitored adequately placing the individual at risk, even with a plan in place. Risk levels often conflicted with information included in the PSP by specific disciplines. Comprehensive risk reviews that considered and analyzed influencing factors contributing to each risk area needed to be completed. All staff needed to be aware of and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. The monitoring team recommends that the facility clarify the purpose and process of the identification of at-risk individuals. MSSLC's Health Status Team (HST) Coordinator was scheduling and conducting meetings according to the policy. An HST meeting was held during the monitoring team's onsite review. The HST was observed and documented to be an interdisciplinary review of risk factors. There was great discussion among team members regarding supports and services needed to address risk factors for individuals. Each discipline contributed to the discussion and appeared to know the individuals being reviewed well. Nevertheless, it was noted that accurate risk levels were not being assigned through this process.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18	Per state policy a risk review at least every six months for each individual was conducted by the MSSLC Health Status Team (HST). The policy identified who should participate on the team and assigned specific responsibilities to team members. The implementation	Noncompliance

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	months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	and ongoing revisions to the process were facilitated by the Health Status Team Coordinator. Determining risk levels was done in a manner that allowed very vulnerable individuals to not be properly identified as being at risk, in part because of the assumption that if a plan, no matter how inadequate, was developed to address the risk, risk no longer existed. Initial change in that process toward more adequate management of individuals' health risks was occurring. Health risk status assessments were completed by members of the PST for most individuals reviewed. These assessments were routinely reviewed by the facility HST and an overall risk level was assigned. Observation of an HST meeting the week of the monitoring visit revealed that the HST engaged in a thorough discussion of each individual's risk factors and all disciplines had input. There was constructive discussion and a collaborative effort made to arrive at an overall risk rating for each individual. As noted above though, the assignment of risk levels did not support the true risk for each individual. This resulted in what appeared to be incorrect ratings of risk for many individuals in important areas of risk and/or failure to increase level of risk in a timely manner such that the likelihood of harm and negative health outcomes was minimized. Identification of risk and adherence with preventive care guidelines are fundamental to the provision of adequate medical care. Individuals were infrequently appropriately assessed for medical risk factors. This resulted in missed opportunities to assess for mitigation of risk factors and implement plans of care to adequately address the risks. This deficiency was clearly demonstrated in the areas of bowel management and management of persons at risk for pneumonia. The facility was not in compliance with this provision item.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as	The policy stated that the Health Status Team (HST), chaired by the Primary Care Provider, would ensure a preventative approach to the health and safety of persons served by assigning each individual a risk level/rating. High Risk (level 1) would apply to an acute or unstable condition that would require increased intensity of intervention to achieve an optimal health outcome. Furthermore, it stated that individuals discharged from the hospital should have their risk level reviewed by the physician. The policy mandated that once a high-risk condition was identified, the PST would meet within five working days to formulate a plan. The plan had to be implemented within 14 days and incorporated into the individual's PSP. The PST was required to meet at least every 30 days to monitor the effectiveness of the plan of care until the individual's condition was stabilized and the risk level was reduced.	Noncompliance

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	possible but within five working days of the individual being identified as at risk.	The current policy allowed for a risk level to be deemed medium risk (level 2) if the individual had adequate supports that were actively monitored for any assigned risk category. Some examples of inconsistencies in risk scores and actual risk factors for individuals are provided below. • Individual #227 had a risk level of 3 indicating a low risk level for falls and injuries, though she had two serious injuries resulting from falls on 7/18/10 and 8/28/10, and five additional minor injuries resulting from falls in the past six months. She was listed low risk for constipation though her PSP list the diagnosis of chronic constipation. • Individual #422 had a risk level of 3 indicating low risk level for constipation and GI issues though her BSP and PSP noted that constipation, peptic ulcer disease, and GERD were chronic conditions and often precursors to her aggressive behavior. • Individual #211 received daily treatment for asthma, but was listed as low risk for respiratory issues. • Individual #523 had a low risk rating for osteoporosis, though he had a current diagnosis of osteoporosis. He was on a modified diet of pureed food and thickened liquids to prevent choking. He was listed as low risk for choking and aspiration. He also had a low risk rating for constipation and GI issues, though his PSP noted both concerns. He was admitted to the hospital in March 2010 and had a g-tube ordered due to repeated aspiration episodes though staff noted he was successful with his previous diet texture when fed by familiar staff. He was admitted to the hospital on 7/20/10 for bowel obstruction and again on 8/13/10 for another episode of aspiration pneumonia. • Individual #378 had diagnoses of chronic constipation and osteopenia, she was considered low risk for both. She was also on a chopped diet, but rated as low risk for choking. She had a plan in place for repositioning every two hours in bed at night to promote better skin integrity and provide pressure relief, but was not identified as being at risk for skin integrity. • Individual #506 was rated as medium risk for polypharmacy and challenging behaviors. He was not considered to be at risk for injuries, but had documented 15 injuries since 3/10/10, three of which were serious injuries including a fracture and laceration requiring sutures in the emergency room. • Individual #481 was on a pureed diet and at risk for aspiration, but listed as low risk for aspiration and choking by the HST. Her PSP noted that she was 17.8 pounds underweight and on a high calorie, double portion diet, but was not listed as being at risk for weight issues. • Individual #469's PSP noted that he was on one-to-one supervision 24 hours a	

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		day to minimize aggression and inappropriate sexual behavior. His risk rating for challenging behaviors was low. • It was observed at the HST meeting that individuals living in locked homes or requiring one-to-one supervision for aggressive behaviors were not always rated as being high risk for challenging behaviors. Review of support plans did not support that adequate preventative measures or plans were in place or that adequate monitoring of implementation was occurring. Thus, the monitoring team could not support the practice of lowering individual's risk level from high to medium just because a plan was in place to address the issue. Until the facility develops an effective plan of monitoring and revising supports as needed, it is recommended that risk levels be assigned cautiously to ensure proactive measures are taken to monitor each individual's health and safety. For the high health risks individuals reviewed (five) in the nursing section of this report (M), all had multiple risks related to their health, and two of the five individuals had behavior risks that compounded their health risks. The apparent correlations between the individuals' health and behavior risks, however, were not adequately identified and/or addressed by the HST. Also, the facility did not have a functioning PST that regularly included psychiatry. Therefore, it would be not be possible for the PST to discuss specific risks associated with the administration of psychotropic medications. Although there were risk/benefit assessments included in the PBSP, these assessments were authored by psychology staff, and were not acceptable. This, however, is an area that would be amenable to collaboration between psychology and psychiatry as part of the PST process. One of the most important aspects of a health risk assessment process is that it effectively prevent the preventable and reduce the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. This feature of health risk assessment is in need of improvement at MSSLC. The facility was not in compliance with this provision item.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. A majority of the PSPs that were reviewed included strategies to address identified risks, but again, not all risks were identified as a risk for each individual. Some identified risks had no individualized plans developed to	Noncompliance

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	implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	address them. Direct care professionals reported that they were notified of changes in plans by therapist, the QMRP, the psychologist, or their supervisor and implementation of changes began immediately. Throughout the onsite monitoring visit, direct support professionals were asked questions by the monitoring team about risks for individuals whom they supported. Staff were generally able to accurately identify primary risks or identify primary supports needed to monitor those risks. Several direct care staff, however, were not able to describe risk for the individuals to whom they were assigned because they were pulled staff and did not regularly work with those individuals. Each home had brief meetings at shift change to share information regarding any changes in health or behavioral status for the individuals in the home. This appeared to be a productive way to ensure that all staff were aware of any changes in status. Information from the home meetings was presented at Unit meetings, and then at the morning Incident Management meeting. This practice ensured that staff at all levels were aware of changes in status and created the opportunity for various staff to identify possible risk factors and make recommendations for changes in the level of support for the individual. As noted throughout this report, intervention plans were often not carried out as written, therefore, individuals remained at risk. The facility was not in compliance with this provision item.	

Recommendations:

1. Develop a system to accurately identify any individuals whose health or safety is at risk. Risk levels should be evaluated considering the level of support needed in each risk area.

2. All staff should receive individual specific training on each safety and health care risk identified for the individuals they are assigned to support and implementation of plans should be routinely monitored.

3. All health issues should be addressed in PSPs and direct care staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues and when to seek medical support.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u> o Organizational chart o Facility policy and procedure manual, and any related departmental manuals. o List of individuals who received pre-treatment sedation medication for medical or dental procedures that included date the pre-sedation was administered, and the name dosage, and route of the medication, and an indication of whether a plan is in place to minimize the need for the use of pre-treatment sedation medication. o A description of any current process by which individuals receiving pre-treatment sedation are evaluated for any needed mental health services beyond desensitization protocols. o A spreadsheet of individuals prescribed psychotropic/psychiatric medication, listing name of individual, residence/home diagnoses, and medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration). o A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use. o A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use. o A list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date. o Facility-wide data regarding polypharmacy, including intra-class polypharmacy. o A list of individuals being monitored for tardive dyskinesia. o A list of individuals with tardive dyskinesia. o A separate list of individuals being prescribed: • Anti-epileptic medication being used as a psychotropic medication, Lithium, Tricyclic antidepressants, Trazodone, Beta blockers being used as a psychotropic medication, Clozaril/clozapine, Mellaril, Serentil o List of new admissions since 1/1/10 and whether a Reiss scale was used. o For five individuals most recently admitted, and for the seven other individuals • Their most recent psychiatric assessment; • Last three psychiatric progress review notes, including data provided to the psychiatrist by the psychologist and/or other team members; and • For the past year, Dates of all Psychiatric Treatment Reviews, Health Services Team notes, MOSES and DISCUS exams, Neurology consults (if any); and The most recent Medical, Pharmacy, and Nursing summaries. • Across these individuals, at least one individual from each psychiatrist's caseload. o A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations.

	o Description of availability of genetic screening for individuals. o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend. o A list and copy of all forms used by the psychiatrists. o Examples of forms used to document side effects, such as AIMS, MOSES, and DISCUS. o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o Job description of psychiatrists. o A list of all psychiatrists, including board status, whether employed or contracted, and number of hours worked each week. o Example of contract with contracted psychiatrists. o CVs of all psychiatrists, including any special training such as forensics and disabilities o Overview of psychiatrists' weekly schedule. o Over the past 12 month, a list of continuing medical education activities attended by medical and psy staff. o Academic affiliations with educational institutions. o For the past six months, minutes from the committee that addresses polypharmacy. o For the last 10 newly prescribed psychotropic medications: • Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication, • signed consent form, • PBSP, and • HRC documentation <u>Additional Documents Reviewed That Were Requested Onsite</u> o Since 1/1/10, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s). o Caseload list for each psychiatrist o Five dental desensitization plans and five medical desensitization plans for Individual #518, Individual #481, Individual #278, Individual #283, and Individual #281 o All data provided and progress notes generated from Dr. LaGrone's clinic for the following individuals: Individual #301, Individual #300, and Individual #458 o All data provided and progress notes generated from Dr. Kendrick's clinic for the following individuals: Individual #159 and Individual #398 o These documents: • Rights section • Consents section • Personal Support Plan (PSP) • Behavioral Services section • Restraint section • Physicians annual medical review

	• Active problem list • All hospital information • Health risk assessment tool • All labs • Psychiatry section • Side effect screening section (MOSES/DISCUS) • Quarterly drug regimen for the last year • All consults • All physician orders • All intergraded progress notes • Comprehensive nursing assessment • Dental section • Social history o For the following individuals: • Individual #449, Individual #260, Individual #139, Individual #506, Individual #408, Individual #354, Individual #488, Individual #398, Individual #422, Individual #105, Individual #519, Individual #481, Individual #458, Individual #569, Individual #104, Individual #360, Individual #6, Individual #92, Individual #361, Individual #110, Individual #456, Individual #37, Individual #523, Individual #563, Individual #80, Individual #351, Individual #289, Individual #404, Individual #427, Individual #524, Individual #78, Individual #302, Individual #5, Individual #242, Individual #158 o List of all individuals with completed comprehensive psychiatric evaluations per Appendix B of the Settlement Agreement o List of all individuals receiving individual therapy o Names of all evidenced based therapy on campus o Names of groups that individuals attend group(Roster) Dates groups suspended in Longhorn for the summer o Any Quality Assurance (QA) for the last six months on health risk assessment or plan associated with polypharmacy o Five nursing post sedation or chemical restraint monitoring checklists o Examples of five completed comprehensive psychiatric assessments per Appendix B. <u>Individual Interviews and Meetings Held</u>: o Meeting regarding forensic issues including: Charlotte Kimmel, Ph.D., Kristen Huff, J.D., Alynn Mitchell, Lorri Haden, J.D., William Meeks, J.D. o Dolores Erfe, M.D., Medical Director o Christopher Ellis, M.D., facility primary care physician o Alan LaGrone, M.D., facility psychiatrist o Norris Buchmeyer, R.N., Chief Nursing Executive o John Sponenberg, D.D.S., facility dentist o Eileen Farber, M.D., facility psychiatrist

	o Ernest Kendrick, M.D., facility psychiatrist o Charlotte Kimmel, Ph.D., Director of Psychology o Matthew Okoro, Pharm.D., Director of Pharmacy <u>Observations Conducted</u>: o Observation of Behavior Therapy Committee for the following individuals: • Individual #401, Individual #105, Individual #452, Individual #458, Individual #481, Individual #519, Individual #6, Individual #520 o Psychiatric Clinic with Dr. LaGrone for the following individuals: • Individual #301, Individual #300, Individual #458 o Psychiatric Clinic with Dr. Kendrick for the following individuals: • Individual #159, Individual #89, Individual #398 o Psychiatric Clinic with Dr. Farber for the following individuals: • Individual #407, Individual #99 o Emergency PSP meeting for Individual #300 o Pharmacy and Therapeutics Committee Meeting o Physicians meeting including all primary care and psychiatric physicians
	Facility Self-Assessment: The facility's self-assessment, its POI, for section J indicated substantial compliance in subsections of one area, provision J11, with regard to having a system in place to monitor at least monthly, polypharmacy by virtue of the fact that the psychotropic polypharmacy review committee had been meeting monthly to review the psychotropic polypharmacy data since November 2009. While there was documentation provided of these meetings (via minutes) the facility continued to experience challenges regarding polypharmacy. For example, the facility pharmacist was using an outdated definition of polypharmacy and, therefore, the group of individuals the pharmacist identified for review was smaller in number and not inclusive of the same individuals identified by the committee. Given this information, this area was found to be in noncompliance per this monitoring report. With the exception of J1, found in substantial compliance in that the facility had qualified psychiatric physicians providing care, the monitoring teams review of the remainder of this provision, as detailed in this section of the report was congruent with the facility's self-assessment. The monitoring team's review was based upon observation, interview, and review of sample of documents. The facility will need to do the same in order to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: Although psychiatry consultations were occurring, MSSLC was found to be in noncompliance with all but one of the items in this provision of the Settlement Agreement. The facility did have physicians, provided by a locum tenens corporation, who were qualified by virtue of their board eligibility/certification status to

	provide services at MSSLC. The facility had a total of 2.7 Full-time Equivalent (FTE) physicians, however, one tendered his resignation during the tour and, with his departure, the facility will have 2.0 FTE. The facility has reportedly had a history of difficulty recruiting and retaining physicians. As such, the primary goal must be to recruit and retain psychiatrists such that the psychiatric program can be expanded to provide clinical services and integrated with other disciplines to meet the requirements of the agreement. The current psychiatric physicians had integrated themselves well with the primary care physicians. There were beginnings of integration with psychology staff, however, this was apparently physician-specific to one psychiatric provider and, unfortunately, this was the provider who was departing. Given the facility's history of reliance on locum tenens physicians, it was recognized that they may experience difficulty with recruitment of a full-time psychiatrist. The medical leadership should consider the development of a recruitment/retention plan for psychiatry, and if this is not successful, should consider the development of a training document that allows new psychiatrists to become quickly familiar with the facility and practice parameters within the facility that comport with the Settlement Agreement so that they can "hit the ground running." While psychiatry was interacting with psychology on some levels, there were marked deficits in the interaction. It was apparent that some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., informed consent and risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of target symptoms, data collection, collaboration regarding case formulation). The staff from both disciplines were aware of the challenges and the need for increased structure and integration, however, they were also aware of the manpower shortage and history of high turnover in psychiatry, which did not lend itself to close collaboration. What was most striking during the tour, was that staff overall were caring and invested in the treatment of the individual and had the desire to see the individual benefit from treatment. Even so, while they were able to verbalize the need for specific treatment interventions and to back these recommendations with clinical evidence, they were stymied when it came to requesting approval for the plans or implementing them.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	MSSLC had a total of 2.7 FTE (full-time equivalent) psychiatrists. All three physicians were either board certified (two) or board eligible (one) in adult psychiatry. One physician was also board certified in child and adolescent psychiatry as well as forensic psychiatry. As such, the physicians were qualified. Of the three physicians, one had been providing services at the facility for over a year. This physician functioned as a leader of the psychiatric clinicians. During this monitoring tour, this physician announced his resignation. Unfortunately, MSSLC had a history of	Substantial Compliance

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		experiencing difficulty in the recruitment and retention of psychiatric physicians. As a result, the facility was reliant upon a locum tenens corporation to provide physician candidates. The use of locum tenens physicians has its own set of challenges, specifically, there is no expectation of permanency. Physicians sign a short-term contract (often 90 days) and if they enjoy the placement, time can be extended. Positively, two of the current physicians had extended their time at MSSLC. Other challenges included the potential for frequent turnover of psychiatric physicians and the difficulty that physicians experience in their integration into the treatment teams. Given the challenges that the facility was experiencing, it was suggested that the facility utilize the remaining time on the senior psychiatric physician's contract to create a recruitment and retention plan for psychiatric physicians. Also, it was recommended that the facility author an orientation/training/introduction regarding the practice of psychiatry within a state supported living center. This may assist physicians with orientation to the facility (i.e., the team concept, the vocabulary, requirements of the Settlement Agreement) and may increase the likelihood that they will remain on the team. Although the psychiatrists practicing at the facility were either board certified or board eligible, the report that follows will indicate areas of concern with regard to their practice at the facility. While it was recognized that many of the challenges could be due to frequent physician turnover, the lack of consultation time available, the lack of appropriate data the physicians were provided, and the lack of their integration into the overall facility treatment program, it was apparent that there were other difficulties with the physician's practice (e.g., documentation issues) that were directly within physician control. Improvements necessary in the quality of services provided will be reviewed over the course of subsequent monitoring visits.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Per interviews with the three psychiatrists providing clinical services at the facility, individuals were seen in clinic a minimum of once per quarter for their quarterly medication review. Review of the records of 35 individuals revealed that in some cases, (generally younger individuals or individuals with significant behavioral challenges) individuals were seen more frequently. For others, the quarterly medication reviews were not always done within a three-month time. Review of the records revealed in some cases, there were five-month periods between clinic visits for quarterly medication reviews. For example: • Individual #5 was seen for quarterly medication reviews on 1/5/10, 4/27/10, and 8/12/10.	Noncompliance

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		• Individual #488 was seen for quarterly reviews on 7/21/10 and 3/31/10. This individual was also seen twice in the intervening period between reviews. The review performed 3/31/10 was grossly inadequate. It read, "patient doing much better since meds were changed back to previous dose/schedule. No major problems/xxx (word illegible). Mental Status Examination – lying in bed, sleeping, xxx (word illegible). Impression- Intermittent Explosive Disorder, very sensitive to any changes in medications. Plan – no change in treatment plan. As this documentation did not suffice for a quarterly medication review (i.e., there was no documented review of health records or data, no documentation of laboratory review), it was opined that this individual had not had an appropriate quarterly medication review. • Individual #158 was seen for quarterly psychiatric medication reviews on 3/9/10 and 8/3/10. He was seen intermittently between these dates for emergent issues on 4/19/10 and 5/12/10. The recent addition of the psychiatric assistants may alleviate some of the scheduling difficulties. Per interviews with staff, it was planned for these two assistants to assume the responsibility for scheduling individuals for their quarterly medication reviews. The psychiatrists had begun comprehensive psychiatric assessments per Appendix B. While all individuals prescribed psychotropic medication had a five-axis diagnosis documented at some time during the last six months, there were records where diagnoses were changed or medication was added during a clinic visit with either no or insufficient documentation of why the changes were made (Individual #569, Individual #104, Individual #458, Individual #80, Individual #563). Details are provided below. The following physician's documentation (progress notes) was for Individual #569: • 1/5/10: "did better for awhile but seems to be slowly getting worse. Specifically described as overactive, but there are no signs or symptoms of ADD. Sleeps well, active in sports, appetite good, denies being depressed. …Impression, I.E.D., Conduct Disorder, PTSD. Plan: discontinue Ritalin." • 1/12/10: "…Ritalin was discontinued. Staff reports no ADD symptoms. May be a bit calmer…not make any changes at this time." • 2/4/10: "patient has been more hyperactive over the last month…tends to be in motion or fidgets…Impression: ADHD. Plan: Trial of Strattera, plan a taper off of Depakote." • 4/6/10: "doing fairly well…tendency toward being hyper and distractible. No signs or symptoms of mania. Doing better on Strattera than on Ritalin. Will discontinue diagnosis of Bipolar Disorder."	

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		The above illustrated the lack of a thorough evaluation with regard to the diagnosis of attention and concentration difficulties for this individual. In order to diagnose ADHD, there are specific criteria that must be met. The documentation of increased activity, "being in motion," and fidgeting are not enough symptoms to meet the diagnosis. Additionally, there was no documentation of the rationale for the plan to taper Depakote. The following physician's documentation (progress notes) was for Individual #104: • 4/8/10: "discontinue 'by history' modifier for ADHD diagnosis and just go with ADHD." There was no corresponding physician progress note. • 6/8/10: "discontinue methylphenidate." Per the corresponding physician progress note: "patient apparently exhibited public masturbation. Does not show any signs of ADHD…Will discontinue methylphenidate (don't believe he has ADHD). See in one week, and probably discontinue ADHD diagnosis, start taper of Abilify and add Paxil. Plan: Discontinue methylphenidate." • 6/15/10: "decrease Abilify 15 mg at bedtime for conduct disorder, discontinue diagnosis of ADHD, add diagnosis of PTSD, add diagnosis of Depression, NOS, add Paxil 20 mg…for depression." Per the corresponding physician progress note: "Patient has done well with discontinuation of Ritalin. No signs or symptoms of ADHD. Does have periodic dreams of past abuse. Also continues to compulsively masturbate in public. Underlying sadness in presentation. Will follow plan in note of 6/8/10 and start taper of Abilify and start on Paxil. Will discontinue diagnosis of ADHD and add diagnosis of PTSD and Depression, NOS." The above was representative of insufficient symptom data documentation for the justification of a specific diagnosis. The experience of periodic dreams does not justify a diagnosis of PTSD, just as "underlying sadness in presentation" does not justify a diagnosis of Depression, NOS. The following physician's documentation (progress notes) was for Individual #458: • 5/20/10: "Discontinue Bipolar Diagnosis, Discontinue diagnosis of ADHD, Add diagnosis of Depression, NOS, Add Paxil 20 mg…for Depression." Per the corresponding physician progress note: "…staff reports a lot of pent up anger over past…has SIB…can get angry easily. Reports auditory hallucinations in past although description of such is poor – sounds like thoughts about his family…doubt diagnosis of Bipolar does appear to have a depression. Doubt ADHD. Plan: Start Paxil." The above was representative of insufficient documentation regarding the alteration of the individual's diagnosis. Also, there was no documentation of the specific diagnostic symptoms for the diagnosis of depression and prescription of the antidepressant	

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		medication Paxil. The following physician's documentation (progress notes) was for Individual #80: • 4/13/10: "Patient continues to have problematic behavior. Stealing stuff and hiding it…always presents as if he is about to pull a con…consider if meets criteria for Conduct Disorder." • 7/20/10: "Patient has been doing well – occasionally fidgets with his hands, but can concentrate quietly for long periods of time…Impression: ADHD." The above was representative of insufficient documentation of the required symptoms for a diagnosis of ADHD. The following physician's documentation (progress notes) was for Individual #563: • 6/29/10: "Patient has not done well – easily upset. Cursing at times. Sleeps okay. No signs or symptoms of psychosis. He indicates he was abused in past…quiet, some handwringing, downcast…suspect anger secondary to past abuse, may be depressed…discontinue Lithium, start Lexapro, consider diagnosis change to Major Depression, PTSD." • 7/27/10: "Patient doing better since Lexapro added…happy…in a good mood…will start taper of Depakote, once off of it, and if doing well, consider change in diagnosis to Major Depressive Disorder, PTSD…decrease Depakote to 500 mg at bedtime." • 8/24/10: "Patient had altercation four days ago on basketball court. Had to be restrained. Tends to be rambunctious. I can not elicit a history of Bipolar Disorder (no mania, just depression)…will change diagnosis to Major Depression…discontinue Depakote, next week change Seroquel to Zyprexa." • 9/7/10: "Staff feels like patient had been doing better. Has not been in restraints for several days and has started being generally helpful. Patient denies any signs or symptoms of depression…little spontaneous talk but no signs or symptoms of depression. Impression: Major Depression, Conduct Disorder. Plan: Discontinue Seroquel, Increase Zyprexa. The above indicated insufficient documentation of the required symptoms to meet criteria for diagnoses, and insufficient documentation of the rationale for the use of specific medications. In review, the indication for Zyprexa was not documented. Overall, better documentation regarding specific diagnoses (rationale, specific symptoms noted) and the rationale for the prescription of psychotropic medication is needed. A review of 35 records of individuals at MSSLC revealed varying quality of the	

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		documentation in the quarterly medication reviews. There were no detailed case formulations, diagnostic information, or descriptions of the justification for the use of specific psychopharmacological agents located in any of the records. Given these deficits, it was difficult to determine the adequacy of the diagnosis and treatment for the individuals and, therefore, this provision item was found to be in noncompliance. It is hoped that increased clinical consultation time will allow for improvements in overall quality of the clinical interaction and documentation thereof. The facility could consider quality assurance monitoring and/or the implementation of a peer review process. For further discussion regarding diagnostic practices, see the discussion below in sections J6 and J10.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Per this provision, individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). In all records reviewed, individuals prescribed medication did have a PBSP on file. During the tour, the meeting of the Behavior Therapy Committee was observed. This meeting was attended by psychology staff and included one of the facility psychiatric physicians. The goal of the meeting was to review the individual PBSP documents (both initial and revisions) and provide feedback to the author regarding the plan. Unfortunately, the psychiatrist appeared preoccupied during the meeting and did not really participate in the discussion. One concern verbalized by staff during the meeting was that, overall, the proposed interventions were complex, and may be difficult for direct care staff to implement. The monitoring team suggested determining the function of the specific challenging behaviors and how this could be utilized to determine specific interventions. The monitoring team also discussed the importance of collaboration between psychology and psychiatry in the case formulation, the joint determination of target symptoms and the descriptors or definitions of the target symptoms, as well as the use of objective rating scales normed for the developmentally disabled population. Further discussion regarding the quality and utility of the PBSP is the subject of provisions relating to psychological services, discussed in section K of this report. As indicated in section K, overall, the PBSPs did not meet the generally accepted professional standard of care. Therefore, it must be considered that some psychotropic medications were being used in lieu of, and perhaps as a substitute for, a comprehensive treatment program. While all individuals prescribed medication had diagnoses noted in the record, there were concerns regarding the justification and case formulation for specific diagnoses as well as the indications for psychotropic medications prescribed to address the diagnoses. For further discussion regarding this issue, please see the discussion below in sections J8 and J13.	Noncompliance

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		There was no indication that psychotropic medications were being used as punishment or for the convenience of staff. There were concerns regarding the lack of documentation of treatment integration between psychiatry and psychology and the need for improved treatment team functioning. Review of the records revealed the following instances where psychiatry was documented as participating in PSP planning. • Psychiatry participation was documented in the record of Individual #422. There was a signature of the psychiatrist on the roster of a meeting dated 7/20/10. Sign in sheets for an additional 24 meetings of the personal support team did not reveal additional documentation of participation. • Psychiatry participation was documented in the record of Individual #481. There was a signature of the psychiatrist on the roster of a meeting dated 9/30/09. Sign in sheets for an additional 54 meetings of the personal support team did not reveal additional documentation of participation. • Psychiatry participation was documented in the record of Individual #6. There was a signature of the psychiatrist on the roster of a meeting dated 8/19/10. Sign in sheets for an additional 29 meetings of the personal support team did not reveal additional documentation of participation. • Psychiatry participation was documented in the record of Individual #458. There was a signature of the psychiatrist on the roster of a meeting dated 6/22/10. Sign in sheets for an additional 16 meetings of the personal support team did not reveal additional documentation of participation. During the tour, the monitoring team had the opportunity to observe one PSP meeting regarding Individual #300. There was good discussion regarding the individual and what interventions could be implemented in an effort to decrease the team's reliance upon restraints (both physical and chemical). The team discussed a plan that they thought would be beneficial, however, then stated that the plan could not be implemented because, "we can't do that.'' The program that they discussed was individualized based on the individual's needs, and it included specific reinforcers for desired behaviors along with plans to allow natural consequences for negative behaviors. The team was adamant that although they opined this was in the individual's best interest, it could not and would not be implemented. This was a common theme over the course of the tour, that staff had good ideas, knew what they should be doing to intervene in a negative behavioral cycle, but felt they were not able to do so. Facility administration should address this issue of "can't do." There were no specific behavioral-pharmacological hypotheses regarding the individual's treatment located in the records reviewed. It will be imperative that psychiatry and psychology staff meet to formulate a cohesive diagnostic summary inclusive of behavioral data and in the process generate a hypothesis regarding	

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		behavioral-pharmacological interventions for each individual.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	Per staff interviews and record review, individuals had not been given pretreatment sedation for dental clinic since July 2009. Per the facility dentist, no physical restraints had been utilized in dental clinic since May 2010. As evidence of the positive relationship between the dentist and individuals, during the onsite tour, the monitoring team witnessed an individual approach the dentist, open her mouth, and say, "look here." The dentist praised the individual for opening her mouth and showing him her teeth. An interview with the facility dentist revealed that dental clinic was doing "informal desensitization" where individuals were scheduled frequently for clinic, and come in briefly, either just to say hello, or to sit in the chair. The dental clinic staff also attempted to individualize the environment (e.g., play Elvis music for one individual who likes this musical genre) or to determine what special accommodations will assist individuals with their dental hygiene. For example, the dentist determined that for some individuals, the toothpaste taste/foaming/burning was indicated. In an effort to assist them, he located a non-alcoholic mouthwash to use for tooth brushing that did not burn or foam. Psychology staff had developed some dental desensitization plans for individuals who experienced difficulties with dental clinic. Five plans provided via the onsite document request regarding Individual #518, Individual #481, Individual #278, Individual #283, and Individual #281 were reviewed. Two plans included documented discussions with the dentist regarding the plan (plans regarding Individual #281 and Individual #283), however, none of the plans required the dentist's signature. It would be best to have the dentist participate in the development of the desensitization plans because dental clinic staff will have to implement some of the interventions, and may have ideas regarding additional interventions that they have discovered via their informal desensitization. Per the onsite document request, there were no current desensitization plans for medical clinic. A review of documentation revealed that there were 26 incidents of pretreatment sedation for medical procedures since January 2010 for procedures, including MRI, CT, mammogram, PAP smear, and colonoscopy. There was also documentation of individuals receiving pretreatment sedation for medical clinic encounters. For example, Individual #481 had sedation for either medical procedures or medical clinic on 8/2/10, 7/28/10, and 7/22/10. Interestingly, this individual was not included on the list of individuals receiving pretreatment sedation provided via the document request. In future monitoring tours, the extent of pretreatment sedation for medical procedures will be reviewed. Individuals who require pre treatment sedation for routine clinic encounters must have a medical desensitization plan. Documentation of the coordination of the pretreatment sedation process with psychiatry	Noncompliance

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		was not located in the records. A review of the psychiatric progress notes for the individual records reviewed did not reveal documentation that the physicians were aware that the individual received additional medication for sedation, or that they were aware of the effects of these medications. This was confirmed via interview of psychiatric staff. This lack of communication was concerning given the potential for interactions between psychotropic medications and the additional medication prescribed for pretreatment sedation. Additionally, medications utilized for pretreatment sedation could result in unwanted challenging behaviors or sedation that could be mistaken by psychiatrists as symptoms of exacerbations of mental illness or as side effects from the regular medication regimen. Further discussion regarding the potential deleterious effects of this lack of communication is included in the discussion regarding provision item J10.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	At the time of this onsite tour, there were a total of three psychiatric physicians providing services through a contract with a locum tenens company. These physicians accounted for 2.7 full-time equivalents (FTE). One of these physicians, a board certified adult psychiatrist, accounted for 0.7 FTE. This physician had been providing services at the facility for approximately 16 months. He was seen as a leader among the psychiatric physicians. Unfortunately, this physician announced his resignation during the tour, with his last scheduled day planned in early November 2010. This physician's departure will be a loss for the facility. In addition, as serving as a leader to the psychiatrists, he had integrated himself into the PSP process and the behavior therapy committee. Another physician, board certified in adult psychiatry, child psychiatry and forensic psychiatry, accounted for one FTE. This physician was working four 10-hour days per week, and shared in on-call duty (after hours and weekends). Per an interview with the facility medical director, this physician was contracted to provide services at the facility through 12/31/10. A third physician, board eligible in adult psychiatry, accounted for one FTE. This physician was working four 10-hour days per week and sharing in on-call duty. This physician reported that the contract for services was recently extended to 12/31/10. A third physician, a board certified adult psychiatrist who was also board eligible in geriatric psychiatry (boards scheduled for 2012), joined the facility psychiatry department one month prior to this monitoring tour. This physician was full-time, and per interview with the monitoring team, the plan was for her to spend 80% of her time in the provision of clinical services, and 20% of her time in the administration of the psychiatric clinic. With the impending loss of 0.7 FTE and a reduction to a total of 2.0 FTE, it will be	Noncompliance

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		impossible for psychiatry to provide sufficient clinical services at the facility. At the time of this monitoring tour, there were 224 individuals prescribed psychotropic medication. With this volume of individuals, which includes the forensic population with the behavioral challenges and increased psychopathology inherent in this population, it is uncertain what the optimal number of FTEs would be for this facility. Unlike the other SSLCs, at MSSLC, psychotropic medications were being reviewed by psychiatry a minimum of quarterly as opposed to monthly. Individuals were seen more frequently, however, if they had adjustments to their medication regimen or were experiencing increased psychiatric symptoms or behavioral challenges. Therefore, it would be useful to develop workload indicators to determine optimal staffing, taking into account not only clinical responsibility, but required meeting time (e.g., physician's meeting, staffing, behavioral management consultation, emergency PSP). Workload indicators refer to methods of objectively determining the correct staffing levels in health facilities. For psychiatric physicians, this would require a determination of the physicians required patient caseload, what clinical services the physicians would be required to provide (e.g., initial evaluations, annual evaluations, quarterly reviews, emergency consultation), what the allowable time for delivery of each clinical activity would be, and what meetings/other non-direct patient care activities the physicians would be required to participate in. This would allow computations to determine the number of full time equivalent psychiatric physicians needed to provide the required services. At the time of this monitoring tour, there were 245 individuals assigned to the psychiatric clinic. As medication reviews were being performed quarterly, this equated to 163.2 hours of consultation time per month, assuming that the consultation can be performed in two hours. The reason for this amount in allowable time was the increased difficulty in the clinical presentation of the individuals living at this facility with their concomitant forensic issues, and the fact that, rather than being reviewed monthly, the facility was performing reviews quarterly. This also equated to 20.4 annual psychiatric evaluations per month. Allowing for three hours per re-evaluation, this equals 61.2 hours of clinical consultation time per month, assuming that the re-evaluation can be performed in three hours. Again, this allowable time is more than that at other facilities, but likely necessary due to the increased complexity of the cases. This indicated that, in the absence of the evaluation of new admissions, attendance at meetings (e.g., polypharmacy committee, behavior therapy committee, physician's meetings, behavior support planning), and/or any other clinical activity, 224.4 physician hours are consumed by clinical consultation. This indicated that 53.42 hours of	

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		physician time per week (or 1.3 FTE) are required for this activity (allowing for a total of 4.2 weeks per month). Given these basic considerations, and the need for improved coordination of psychiatric treatment with primary care, neurology, other medical consultants, pharmacy, and psychology, a minimum of 3.0 FTE physicians appears to be necessary at this facility. The monitoring team can be available to further discuss the determination of optimal FTEs if the state would like. In addition, it was recommended during the facility tour that medical administration make use of the remainder of the outgoing physician's consultation time in order to assist with the development of a recruitment/retention plan for psychiatry.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	The facility had a policy and procedure entitled "Prescribing of Psychoactive Medication" dated 5/20/09. This policy did not include specific requirements of services as outlined in the Settlement Agreement, nor did it reference Appendix B. DADS had recently created a policy and procedure for psychiatric services addressing the requirements of the Settlement Agreement inclusive of Appendix B, therefore, the facility-specific policy and procedure should be revised to reflect the overarching DADS policy. Nevertheless, the facility psychiatric staff were in the process of evaluating individuals treated in psychiatry clinic as per the requirements and outline of Appendix B. At the time of the monitoring tour, however, there was documentation provided that 60 individuals had been evaluated per the outline of Appendix B. Of these, five were requested for review (examples from all three current facility psychiatrists). These included evaluations regarding Individual #262, Individual #398, Individual #559, Individual #534, and Individual #445. In general, the physicians followed the required format and, overall, the evaluations were acceptable with exception of the case formulation and treatment plan regarding psychotropic medication. The case formulations reviewed in the five examples provided were brief and incomplete. A case formulation should provide information regarding the individual's diagnoses, the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. For additional information, the staff may want to refer to the following article: Ross, D.E. (2000). A method for developing a biopsychosocial formulation. Journal of Child and Family Studies, 9(1), pp. 1-6. With regard to the treatment plans for psychotropic medication reviewed, these were authored by psychology staff, and should be authored either by psychiatric physicians or via a collaborative process between psychiatry and psychology. The plans should include the indication for the medication, the dosage, the route of administration, the target	Noncompliance

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		symptoms, the goals and objectives of treatment with specific medication, and how the individual's response to the specific medication will be determined. The evaluations differed across the physicians with regard to the detail and comprehensiveness of the case formulation and treatment plan. This is an area that would be amenable to physician peer review and education. Per interviews with psychiatric clinic staff and psychiatric physicians, their goal was to complete the required psychiatric evaluations per Appendix B for all individuals treated in psychiatry clinic. Given this goal, a more robust review of these assessments will be performed during future monitoring visits. During the tour, three psychiatric clinics were observed. In all three instances, the physician spent a sufficient amount of time with the individual (a minimum of 30 minutes in all instances except one, where the individual became angry and walked out of the room), either observing them or engaging them in direct discussion. In all three instances, the physician appeared to be familiar with the individual's history, and had the medical record open, reviewing documents from the record during clinic. In all three instances, other staff, including the nursing case manager, QMRP, psychology and direct care staff were in attendance. One issue observed in two of the three clinics, was the overall level of disorganization displayed by the team members. For example, in two of the three observations, staff were engaging in side conversations while the physician was attempting to interview the individual. Also, the scheduling of clinic was haphazard. In one clinic observed, staff did not know who was scheduled for clinic. Once it was determined who was scheduled, staff did not know if this individual was aware that he was scheduled for clinic, or if he would be attending. This resulted in a waste of approximately 30 minutes of staff time (not only psychiatry, but other professionals as well). It appeared that there were no staff members taking responsibility for the overall schedule and structure of clinic. It was understandable that treatment team interactions at the facility were flat, in that there was no hierarchy of personnel with respect to input or decision making, however, there needs to be one specified team member who is empowered to act as a parliamentarian, ensuring that conversations occur one at a time, that all input is heard and respected, and that the schedule was determined and followed. Otherwise, clinical interactions are hampered and time is wasted. During the tour, two staff members, recently hired, were introduced as psychiatric assistants. Per discussions with the medical director, it was planned for these staff members to schedule clinic and provide other administrative assistance to the psychiatric physicians. It was hoped that this could alleviate some of the issues noted	

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		above.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The Reiss screen is an instrument that was developed to identify individuals who may need a psychiatric evaluation. Per an interview with the Director of Psychology, the facility had performed Reiss Screens on all new admissions since January 2010. Also, every individual residing at the facility was screened. She reported that there were no individuals identified per the general screening who required psychiatric intervention. She indicated that this "may mean we do a good job of determining who needs psychiatric services… but 100% of the individuals admitted to the facility see the psychiatrist anyway…so they get screened regardless." The Director was not sure of the utility of the instrument for this facility, as she reported it was the facility practice to perform psychiatric evaluations on all new admissions regardless of their psychotropic medication status upon admission. A review of the listing of individuals who had a completed Reiss screen provided by the facility revealed that since January 2010, of the 45 individuals admitted, 22 did not have the Reiss screen completed. For the first 10 individuals for whom the screen was not completed, there was no additional information provided as to why. Since 7/14/10, there had been 11 admissions and for all of these admissions, the Reiss screen was not completed, and documentation stated, "not used/no suitable respondent was available." As specific data regarding the psychiatric evaluation of all new admissions was not requested, it was not possible to determine if all new admissions were receiving psychiatric evaluation. This will need to be determined in future tours. For now, given concerns that 48% of new admissions had documentation that the Reiss Screen was not completed, this provision will remain rated in noncompliance.	Noncompliance
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The facility did not have a system to integrate pharmacological treatment with behavioral and other interventions. Review of the records did not reveal any collaborative or combined case assessments or diagnostic formulations. There were beginnings of integration between psychiatry and psychology, however, these were reliant upon the efforts of one particular physician who announced plans to resign. Other physicians practicing onsite had not been as involved, and now will have additional clinical duties barring participation. There were opportunities for interaction during psychiatry clinic; these were observed with all three psychiatrists and were a base upon which to build integration. One area of integration that required attention was regarding the use of data. While some of the target data points were documented in the record as the impetus for medication adjustments, both psychiatry and psychology staff voiced concern regarding	Noncompliance

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		the accuracy of data collection, and the accuracy of the choice of individual target behaviors. It was also notable that, while there were some graphs of data presented to the physician, these did not include other potential antecedents for changes in target behavior frequency, such as changes in the individual's life (e.g., change in preferred staff, death of a family member), social and situational factors (e.g., move to a new home, begin a new job), or health-related variables (e.g., illnesses, allergies). Also see section K of this report. Medication decisions made during clinic observations conducted during this onsite monitoring tour were based on the information provided during the time of the clinic. For example, in the clinical encounter regarding Individual #301, the dosage of antipsychotic medication (Haldol) was increased from a total of 30 mg per day to a total of 40 mg per day. The physician solicited information from the facility staff in clinic, and was noted to review the individual's health record briefly. There were no graphs of data or any other long-term data reviewed. Similar events occurred in the clinical encounter regarding Individual #300. There was discussion regarding the individual's most recent behavioral challenges, but no review of long range data. During the clinical encounter, a benzodiazepine was prescribed and an antiepileptic medication was discontinued. Positively, the physician did request data during the encounter due to plans to consider an alternate diagnosis for the individual. These medication decisions were not based on a long-range view of the individual's behavior/symptom presentation. In another clinical encounter, the physician did have access to long range data, and graphs. It was reported that this was because the physician came to clinic early and downloaded information onto his personal computer so that the information could be accessed during clinic. Admittedly, there would be challenges to overcome in order to increase the use of, and breadth of, data presented during clinic. For example, computer access was not available in all clinic settings. A review of the psychological and psychiatric documentation for 35 individual records did not reveal case formulations that tied together the information regarding a particular individual's case. Psychology and psychiatry need to formulate diagnoses and plans for treatment as a team. There was no documentation located regarding objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions.	
J9	Commencing within six months of the Effective Date hereof and with	Per interviews of psychiatrists and psychology staff, as well as an observation of the Behavior Therapy Committee meeting, psychiatry was superficially involved in the PBSP	Noncompliance

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	full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	process. There was one facility psychiatrist who was noted to attend, however, during the observation, he was distracted and did not actively participate in the meeting. Unfortunately, this physician, who per staff interview had been an active participant in the past, tendered his resignation during the tour. Staff expressed concern that following this physician's departure, the remaining physicians will be overburdened with regular clinic demands and will not have the availability to participate in behavior support planning. During the observation of the Behavior Therapy Committee, six PBSP documents were reviewed. The following issues were identified with these documents: • Individual #519 was diagnosed with Depression, not otherwise specified. This individual was not being monitored for mood symptoms, although it was documented that the individual had been experiencing difficulties with weight loss, sleepiness, and sadness. There were no objective data available regarding her mood (e.g., depression scales). • Individual #481 was diagnosed with Impulse Control Disorder. Per report, this individual had been experiencing difficulties with sleep, and a medication had recently been added to address sleep issues. Unfortunately, sleep was not a target symptom being monitored. During the meeting, the addition of a diagnosis of primary insomnia was also discussed. • Individual #6 was diagnosed with Schizoaffective Disorder, Bipolar Type and Borderline Personality Disorder. Reportedly, many of this individual's behavioral challenges were the result of the diagnosed Axis II pathology. This individual was not receiving evidenced based treatment for this, instead, the individual was enrolled in anger management. • Individual #408 was diagnosed with Major Depressive Disorder, recurrent, severe. This individual was not being monitored for mood symptoms. • Individual #458 was diagnosed with Depression, not otherwise specified. There was documentation that this individual was aggressive, had demonstrated suicidal gestures, and had verbalized feeling sad. This individual was not being monitored for signs or symptoms of depression and there was no objective data regarding his mood (e.g., depression scales). In all of the above cases, psychotropic medication was being prescribed. It was difficult from the data reported to discern the benefits of the medication, or the benefits of the PBSP with respect to the individuals. The improvement in integration of the psychiatric physician into PBSP planning is necessary. A review of various other PBSP documents revealed that the psychiatrist who attended the Behavior Therapy Committee had signed as a member of the committee in the	

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		approval of the PBSP. The individual's assigned physician generally was not a signatory on the final plan. This presents a challenge because, while the participation of a psychiatrist in committee is good, participation of the individual's actual treating psychiatrist is the generally accepted professional standard of care. This would allow for collaboration with regard to the identification and definition of target symptoms for monitoring. It may also serve to decrease the reliance on psychotropic medication. Psychiatrists were aware that in many cases, the behavioral interventions, behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports were not coordinated with the psychiatric diagnosis or psychotropic medications.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	A review of the records of 35 individuals at the facility who were prescribed various psychotropic medications did not reveal documentation by the psychiatric physician of an individualized specific risk/benefit analysis with regard to treatment with medication as required by this provision item. There were comments included in the positive behavioral support plans and in the Human Rights Committee (HRC) review of the positive behavior support plans, however, these did not satisfy the requirements of this provision item. For example: • Individual #158 was prescribed psychotropic medication including Clozaril and Trazodone. The risks of the medication were included, and the documented risks of not receiving medication/expected benefits were rote and not individualized, "the benefit of receiving psychoactive medication is to increase his ability to function and participate in life, training, and social activities…without proper medication therapy, his mental status will deteriorate and his functioning will be significantly reduced and consequently, he may become dysfunctional." Alternatives to medication included "active participation in an ongoing positive behavior support program…in group therapy." • Individual #354 was prescribed psychotropic medication including Depakote, Abilify, Lithium SR, and Haldol. The documented risks of not receiving medication/expected benefits stated, "Increased mood and thought disorder symptoms typical of individuals diagnosed with Schizoaffective Disorder…alternatives…to medication…positive behavior support programming." The documentation noted above was typical of the records of individuals prescribed medication. What was curious was that the risk/benefit/alternatives to medication were being authored and presented to the individuals or their legally authorized representative by psychology staff. This is akin to the issue discussed in provision J14, where psychology staff were responsible for obtaining consent to treatment with	Noncompliance

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		psychotropic medication. The above illustrated the need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially more dangerous, than the medications. The success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring is provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician review said data, and that this information is utilized in the risk/benefit analysis. The input of the various disciplines must be documented in order for the facility to meet the requirements of this provision item.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The facility had in place a review system for polypharmacy that was centered in the pharmacy department. Per the document request submitted prior to the monitoring tour, the facility was to provide data regarding a list of individuals prescribed intra-class polypharmacy, including the names of the medications prescribed and the medication's start date, as well as facility-wide data regarding polypharmacy including intra-class polypharmacy. The facility had also recently instituted a "Psychoactive Medication Polypharmacy Review Committee." There was concern that the information submitted by the pharmacy regarding this provision was incorrect. Per interviews with the facility medical director and the pharmacist, the pharmacist was utilizing an incorrect definition of polypharmacy in determining what individual's medication regimen met criteria for this classification. During the tour, this was corrected with the pharmacist and he planned to utilize the correct definition in the future. Per the facility's psychiatry services policy, the correct definition of polypharmacy read, "individuals that are prescribed two or more psychoactive/psychotropic medications from the same class, or three or more psychoactive/psychoactive medications, regardless of the class." The incorrect definition that was being utilized stated during the onsite tour was "polypharmacy exists if three or more medications *for the same indication* or two or more medications in the same therapeutic class." As a result of the inaccurate data, these data were not utilized in the review of this provision. The facility did provide data from the monthly polypharmacy review committee. There were minutes available from meetings dated 5/25/10, 6/29/10 and 7/27/10. A review of these minutes revealed documentation of discussion regarding the	Noncompliance

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		rationale for an individual's psychotropic medication regimen that while not complete, was far superior to any information located in the individual's medical record. This information could be expanded by the assigned clinician and utilized in the individual's record as justification for polypharmacy because none of the records reviewed revealed a detailed description of the potential interactions or problems inherent in the prescription of multiple psychotropic medications authored by the psychiatrist Given the inaccuracies in the data reporting from pharmacy, it was impossible to determine the number of individuals who currently had a polypharmacy designation. Via a review of the list of individuals designated via the polypharmacy committee, there were 55 individuals identified. Given the above information, it was easy to see that the facility staff needed to focus on the collection, collation, and presentation of polypharmacy data, not only for the purposes of monitoring, but, more importantly, for the purposes of the facility review of data. A review of the records of 35 individuals prescribed psychotropic medication revealed that in each record, there was a quarterly medication review document authored by the facility pharmacist. These documents were not really useful. The majority of the documents were handwritten and illegible. Again, the designation of polypharmacy was not correct due to the pharmacy department's use of an outdated definition of polypharmacy. The treating psychiatrist signed the documents, however, information from this review was not noted in the monthly or quarterly psychiatric progress notes. It was recommended during the monitoring tour that the facility consider allowing the pharmacist to meet with other facility pharmacists in an effort to improve services and documentation consistent with the Settlement Agreement. Polypharmacy was routinely noted in Health Status Team Recommendations. Team members, including the primary care provider and the psychiatrist, signed these documents. These documents were confusing, as they did not always reveal how a certain risk level was determined. For example, Individual #488, who was prescribed psychotropic medications including alprazolam, benztropine, escitalopram, trazodone, and haloperidol, was determined to be at low risk for polypharmacy via the Health Risk Assessment on 3/23/10. Per the Quarterly Drug Regimen Review authored by the facility pharmacist, it was determined that the individual did not meet criteria for polypharmacy (see discussion above for information regarding this discrepancy). Individual #361 was found to be at low risk for polypharmacy via the Health Risk Assessment on 4/13/10. This individual was prescribed benztropine, Divalproex ER, haloperidol, quetiapine, and trazodone. From a review of the discussion above, it is apparent that the determination of	

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		polypharmacy via the review committee, pharmacy, and the physicians must be coordinated. Also, there must be justification for polypharmacy (i.e., the rationale for the current regimen) included in the individual's record. Additionally, the Health Status Team must review the individual's medication regimen and appropriately determine risk of the regimen.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The review of a sample of 35 records revealed documentation that the Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) were being performed by the Nurse Case Manager. There was evidence that the scales were not being performed according to the time period required by the Health Care Guidelines (i.e., DISCUS immediately prior to initiating therapy as a baseline and every three months during treatment and for six months following discontinuation of a Neuroleptic medication. The MOSES will also be completed every six month). In some cases, the prescribing psychiatrist signed off as having reviewed the rating scales. In no cases reviewed was there documentation regarding how the information would be utilized in the prescriber review section. The following case examples were chosen randomly from the 35 records reviewed: • Individual #302 was prescribed an atypical antipsychotic. MOSES monitoring had been performed on 5/11/09, 7/6/09, and 8/17/09. DISCUS monitoring had been performed 5/11/09, 7/7/09, 8/17/09, 2/19/10, and 8/11/10. Of these scales, the prescribing physician signed all, but the time requirement for both of these instruments was not met. A review of psychiatric clinic documentation did not reveal documentation of any clinical coordination of the information obtained from these documents, nor did it reveal notations by the physician of the need for more regular rating with these documents. • Individual #92 was prescribed an antipsychotic medication. MOSES monitoring had been performed 10/15/09, 1/20/10, 2/25/10, 5/21/10, and 7/7/10. Of these, the prescribing physician signed two. DISCUS monitoring was performed 10/15/09, 1/20/10, 2/25/10, 6/1/10, and 7/7/10. Of these, the prescribing physician signed two. In this case, the screening was being performed at an increased frequency, more than required. A review of the integrated progress notes in this individuals record revealed that in quarterly medication reviews dated 3/2/10 and 8/3/10, the results of these screens and the clinical integration of this information was not noted (also, there is a period of five months between these quarterly reviews, which should occur every four months). • Individual #449 was prescribed an atypical antipsychotic medication. MOSES monitoring was performed 11/13/09, 1/21/10, 4/8/10, and 4/28/10. The physician signed one of these documents. DISCUS monitoring was performed	Noncompliance

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		11/13/09, 1/21/10, 4/8/10, and 4/28/10. The physician signed three of these documents. In this case, the time requirement for the completion of these documents was not met. A review of psychiatric progress notes dated 3/2/10, 4/9/10, and 6/11/10 did not reveal documentation of the results of these screens or the clinical integration of this information with other data. • Individual #458 was prescribed atypical antipsychotic medication. MOSES monitoring was performed 7/5/10 and signed by the physician with no notation in the prescriber review section. DISCUS was performed 7/6/10 and signed by the physician with no notation in the prescriber review section. Review of the physician's progress notes revealed no further documentation of the results of these screens or clinical integration of these data on subsequent dates of clinical contact. Reviews of the records did not reveal the use of MOSES or DISCUS in clinical decision-making. In an effort to address the need for documentation of data review and the impact of said data in clinical decision making, the facility could consider physician education regarding documentation requirements, quality assurance monitoring with ongoing corrective action, or a peer review process utilizing physician reviewers from another DADS facility. Also, the frequency of monitoring was concerning. The screens were either being performed too frequently, or not frequently enough. It would benefit the facility nursing staff to have a regular re-occurring schedule for these screens so that they are performed within the appropriate time frame. It would be beneficial to review the MOSES and DISCUS documentation for individuals diagnosed with Tardive Dyskinesia to ensure that their symptoms were being appropriately noted.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral	At the time of the onsite monitoring tour, the facility psychiatrists were reportedly participating in some PSP activities. Per staff interviews, the psychiatrists "come when they can…but if it is an emergency PSP they can't usually make it…" The physicians had contact with other members of the treatment team during psychiatric clinic, however. There was not a separate treatment planning document regarding psychotropic medications. Instead, this was done via the quarterly medication reviews, according to staff interviews. There were references to psychotropic medications in some of the PSP documents reviewed. Even so, this was insufficient to meet the requirements of this provision item. A review of the PSP sign in sheets from the records available for review revealed concerns that psychiatry was not able to attend PSP meetings. For example: • Individual #139 – between 5/5/10 and 8/30/10 there were 12 meetings of the PSP. These included issues of weight management (the individual was	Noncompliance

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	characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	prescribed Zyprexa, Haldol, Depakote ER, Cogentin) and suicidal threat. No psychiatrist attended any of the PSP meetings per the sign in sheets. • Individual #456 – between 12/17/10 and 8/25/ 10 there were 17 meetings of the PSP for issues including incidents and "new medication." No psychiatrist attended any of the PSP meetings per the sign in sheets. • Individual #5 – between 4/19/10 and 7/29/10 there were seven meetings of the PSP. These included the annual PSP meeting. No psychiatrist attended any of the PSP meetings per the sign in sheets. • Individual #449 – between 7/13/10 and 9/2/10 there were eight meetings of the PSP. No psychiatrist attended any of the PSP meetings per the sign in sheets. • Individual #569 –between 6/7/10 and 8/13/10 there were three meetings of the PSP. No psychiatrist attended any of the PSP meetings per the sign in sheets. In review of the psychiatric documentation from the records of 35 individuals, the documentation of the case formulation, diagnostic impression, and psychiatric treatment planning varied from record to record. For those individuals whose initial psychiatric evaluation had been completed according to the requirements of Appendix B (60), the documentation was overall better, however, there remained marked variability in this documentation. The facility had made some strides with providing assessments via Appendix B, which should result in better documentation to satisfy the requirements of this provision. Further examples will be randomly chosen from among those records inclusive of Appendix B assessments. • Individual #262- In the initial psychiatric evaluation per Appendix B documented in this individual's record, diagnoses, including PTSD and conduct disorder, were assigned. The case formulation included three sentences that did not provide enough information to justify the diagnoses. The treatment recommendations included plans to taper two medications and add a third medication. There was no notation regarding the target symptoms for the additional medication, or what possible effect the taper and discontinuation of the two medications could have. There was no behavioral psychopharmacological hypothesis included. • Individual #398 – This individual had a comprehensive psychiatric evaluation per Appendix B dated 8/26/10. Per this document, diagnoses included Intermittent Explosive Disorder, Mild Mental Retardation, Diabetes and Obesity. The case formulation did not review the specific target symptoms or diagnostic criteria that resulted in the assignment of Intermittent Explosive Disorder as a diagnosis. The case formulation did describe symptoms including "longstanding severe difficulties with interpersonal relationships…propensity for	

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		impulsive/compulsive action during times of increased expressed emotionality…" These symptoms and the clinical data included in the individual's history were more reminiscent of Axis II pathology. (Note that this exact language was used in the case formulations of multiple individuals). This individual was prescribed medications including Lithium, Thorazine, Haldol, Trileptal, Cogentin, and Klonopin (although elsewhere, it was documented that Klonopin had been discontinued as of 3/16/10). The indication for these medications, per the comprehensive psychiatric assessment, was mood disorder, not otherwise specified. This diagnosis was not included in the final diagnostic assessment. There was no documentation of a specific behavioral-psychopharmacological hypothesis located. It was unclear what specific target symptoms for medication were. In a subsequent integrated progress noted dated 9/14/10, target behaviors being monitored were listed as aggression, self-injury, and departure. There was no note of monitoring of mood symptoms. This note also revised the assigned diagnoses as Mood Disorder, NOS; Mental Retardation, Mild; and Borderline Personality Traits. There was no case formulation documented regarding the rationale for the change in diagnoses. The document reviewed goals for treatment including decreases in aggression, SIB, unauthorized departure, falsely accusing others, and increases in expressing need for social attention without display of problem behaviors, as well as calm and cooperative participation in activities. Even with the above, the individual reportedly continued to experience significant difficulties in the milieu. This case illustrated the difficulties that may arise when a collaborative case formulation is not included. The diagnoses/medication/target symptom monitoring were not integrated. Further review of the psychiatric documentation revealed that in approximately 75% of the 35 cases reviewed, there was some connection between the medication prescribed and the diagnosis, however, there were more frequent challenges noted with respect to the target symptoms chosen for monitoring. Again, it was opined that the lack of a cohesive case conceptualization (i.e., documentation of diagnostic formulation, rationale regarding psychotropic medication regimen complete with plans regarding regimen alteration, and corresponding behavioral hypothesis and data collection) resulted in challenges related to the satisfaction of this provision. For example: • Individual #408 was prescribed antipsychotic medication for an indication of schizoaffective disorder. His current diagnoses did not list a psychotic disorder. Per a review of the behavior support plan, neither psychotic symptoms nor mood symptoms were being monitored. • Individual #139 was prescribed antipsychotic medications for an indication of psychotic symptoms due to a diagnosis of Schizophrenia. A review of this	

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		individual's behavior support plan and target symptoms did not reveal any monitoring of psychotic symptoms. • Individual #563 was prescribed mood stabilizing medications (antiepileptic medication, atypical antipsychotic medication, antihypertensive medication, and Lithium) due to a diagnosis of rule out bipolar mood disorder (per the initial psychiatric evaluation 7/20/10. Per the behavior support plan, mood symptoms were not being monitored or targeted. A review of the integrated physician progress notes regarding this individual revealed multiple diagnostic changes with no discussion of the rationale behind the change of diagnosis. • Individual #158 was prescribed antipsychotic medication for schizophrenia with a corresponding diagnosis of schizophrenia. He was also prescribed a medication for sleep. A review of the target behaviors for monitoring did not include psychotic symptoms nor did it include sleep. The above examples illustrated the need for medication treatment plans that outlined a justification for a diagnosis as well as a thoughtful planned approach to psychopharmacological interventions and the monitoring of specific target symptoms to determine the efficacy of the prescribed medication. Dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response via a clinical encounter with the individual and a review of appropriate target data (both pre and post the medication adjustment), the physician can determine the benefit, or lack thereof, of a medication adjustment.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	In response to the monitoring team's document request regarding a listing of all facility-wide policy and procedures, the facility provided a listing of policies including one entitled "Prescribing of Psychoactive Medications" with an effective date of 5/20/09. This policy referenced the Texas Administrative Code Title 25, Part II, Chapter 414 Subchapter I as delineating procedures regarding consent to treatment with psychotropic medications. An internet search revealed that per this policy "the treating physician, registered nurse, licensed vocational nurse, physician's assistant, or registered pharmacist" is responsible for obtaining informed consent for treatment with psychotropic medications. The policy further stated, that if the information was not provided by the treating physician, they must "confirm the explanation with the patient and the patient's legally authorized representative, within two working days." Per interviews with facility staff, including the Director of Nursing, the facility pharmacist, the Director of Psychology, and the facility psychiatrists, as well as review of facility medical records, psychology staff were responsible for completing the consent form for medication and presenting same to the individual or their legally authorized representative for signature. Numerous examples of the consent forms utilized were	Noncompliance

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		noted in the individual's records. In most cases, there was an incomplete listing of potential side effects of the medication, as well as a route description of the benefits of the medication (e.g., "increased ability to develop appropriate relationships and to progress toward reintegration into the community). There were no listings of alternatives to treatment or what would/could occur if consent were not given. The facility superintendent, the individual, or the individual's legally authorized representative signed the form. There was no notation of who provided the signer with the information, or who responded to any questions elicited by the request for consent. The informed consent process at the facility was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual the risks, benefits, side effects, alternatives to treatment, potential consequences for lack of treatment, as well as give the individual or his or her legally authorized representative the opportunity to ask questions in order to ensure their understanding of the information. This process must be documented in the individual's record. To delegate this responsibility to psychology staff, who do not have prescriptive authority and would not be able to respond to specific questions an individual or legally authorized representative may have regarding the specific medication was inappropriate. In an effort to address the deficit in these informed consent practices, it was recommended that the facility consult with the state office who, in turn, may want to consider a statewide policy and procedure outlining appropriate informed consent practices that comply with Texas state law and generally accepted medical practice. In a separate but related issue, review of the medical records revealed information regarding the individual and his or her guardianship status, however, this information was not included in the psychiatric annual evaluations or progress notes. Easy identification of an individual's guardianship status for the purposes of consent is necessary. Inclusion of this information in the demographic data located in the beginning of the psychiatric evaluations/progress notes may assist in this regard. Also see section U of this report.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they	Per interviews with the three facility psychiatric physicians, the facility medical director and one facility primary care physician, coordination of treatment between neurology and psychiatry was occurring with the primary care physician functioning as a conduit of information as described below. This indirect contact with neurology was not effective. Given the difficulties outlined, this provision was found to be in noncompliance. The facility did not have a regular neurologic consultative service. Instead, individuals	Noncompliance

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	are prescribed to treat both seizures and a mental health disorder.	must travel approximately two hours to receive neurological services at Scott & White hospital in Temple, Texas. Information gleaned as a result of these clinical encounters was then returned to the facility as a consultative report that was transmitted to the primary care physician and ultimately shared with the psychiatrist. Psychiatric physicians reportedly had the ability to contact the individual's consulting neurologist via telephone, however, per report, this was rarely done and documented evidence of same was not located in the records reviewed. Per interviews and observation of medical staff, there were obvious attempts at coordination of care occurring specifically between primary care and psychiatry. The physicians met together daily to review cases (regarding individuals who were hospitalized and individuals who were experiencing difficulties or challenges). While these attempts at communication were laudable, the risk was for transmission of non-emergent information to be hindered by the indirect contact between psychiatry and neurology. A review of the list of medications prescribed to the individuals as well as the indications for said medication revealed that 224 individuals were prescribed psychotropic medication and that 47 of these individuals (21%) were also prescribed medication for seizure disorder. While this would indicate the need for clinical consultation, there were other neurological disorders diagnosed that would have been amenable to close clinical contact between neurology and psychiatry (e.g., headache, EPS, tremors, various syndromes). A review of five records chosen for review due to comorbid diagnoses of psychiatric illness and seizure disorder revealed various challenges which were likely attributable to the lack of sufficient neurological consultation and collaboration. For example: • Individual #506's patient profile provided via the pharmacy revealed a prescription of Divalproex ER for seizure disorder. A review of this individual's record revealed no history of a diagnosis of seizure per the physician's annual medical review dated 5/10/10. This document did not list Divalproex ER as a current medication either. Additional chart review revealed an emergency physician record dated 5/29/09 with a chief complaint of "possible seizure" noting two episodes of unresponsive staring episodes, and documenting "missed recent doses of seizure medication." This individual was seen in neurology clinic at Scott & White 8/7/09, which, per documentation revealed, "referred for evaluation of…seizure…observed at Mexia…he used to have seizures before admission…Depakote was discontinued in January 2009…he had a seizure on May 29, 2009…blank stare, twitching, followed by generalized convulsion lasting for greater than 8 minutes, associated with tongue bite and urine incontinence.	

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		Depakote was resumed at that time…well controlled on Depakote…seizure precautions discussed with the patient and the Mexia state school staff. I will see him back in 1 year." There were no additional documents from neurology clinic available for review. It was not clear whether this individual had been scheduled to follow up with neurology. As per the most recent annual medical review, this diagnosis was not noted. Also, the consultation was not noted in the Nursing Assessment dated 4/7/10. This document also did not note a history of seizure disorder. Review of the most recent psychiatric progress noted dated 5/13/10 revealed that the psychiatric physician had adjusted the timing of the administration of Depakote ER in March 2010, and that seizure disorder was not a consideration per the listing of diagnoses. Also, other medication adjustments had been made by psychiatry (2/15/10) with no documentation of consideration of seizure potentiation or documentation of seizure in the listing of diagnoses. • Individual #351 had a history of seizure disorder. In early 2010, in an effort to address psychiatric symptoms, the dosage of Clozaril prescribed to this individual was increased. Shortly after, there was documentation regarding difficulty regulating the individual's Dilantin level. The dosage of this medication was adjusted on several occasions due to his experiencing toxicity within a very narrow dosage adjustment window. Unfortunately, documentation of a neurological consultation was not located for this individual. While psychiatry did note the need to review neurological consultation for this individual, this was in August 2010, following a flurry of seizure activity. The potential difficulties in regulating the dosage of both of these medications due to pharmacokinetic interactions was not documented as a consideration for the challenges the individual had been experiencing. It would be beneficial to determine the amount of clinical neurology time needed via an examination of the number of individuals in need of neurology (including those not prescribed concomitant psychotropic medication) consultation and the recommended follow-up frequency. The facility may want to consider options for improving neurologic consultation availability, specifically increasing the contract with the current provider, exploring consultation with local medical schools and clinics, and considering telemedicine consultation with providers current contracted in other DADS facilities.	

Recommendations:

1. Integrate psychiatry into the overall treatment program at the facility. This would include involving the psychiatrists in discussions regarding treatment planning and behavioral support planning.

2. Review those individuals requiring pretreatment sedation for medical clinic and prepare desensitization plans for them.

3. Ensure that psychiatry is aware of when an individual requires pretreatment sedation and documents this knowledge in his or her progress notes.

4. Ensure that the target behaviors/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication are appropriate. This must include a detailed case formulation and discussion that is collaborative with other team members. In addition, there should be a detailed psychopharmacological treatment plan. When diagnoses or medications are changed, there should documentation of what symptoms or criteria was met in order to justify an alteration of diagnosis. When a medication is added, or a dosage is changed, there should also be documentation regarding potential difficulties that may occur and symptoms that are being targeted with these changes.

5. Draft and implement policy and procedure governing psychiatric clinic at the facility to include requirements of the Settlement Agreement, Appendix B, and the overarching DADS policy.

6. Complete annual psychiatric evaluations following the requirements of the Settlement Agreement Appendix B. These must include detailed case formulations and treatment plans for psychotropic medication.

7. Examine the scheduling process of psychiatric clinic at the facility.

8. Implement the Reiss screen for new admissions as well as those individuals who do not have a current psychiatric evaluation.

9. If the Reiss screen is not completed, document the reason why and if a psychiatric evaluation will be performed in lieu of the screen.

10. Review the target symptoms and data points currently being collected for individuals prescribed psychotropic medication. Make adjustments to the data collection process (i.e., specific data points) that will assist psychiatry in making informed decisions regarding psychotropic medications. This data must be presented in a manner that is useful to the physician (i.e., in graph form, with medication adjustments, identified antecedents, and specific stressors identified).

11. Formalization of the PSP process to review risk/benefit ratios for the prescription of psychotropic medications that are authored either by psychiatry or at a minimum in collaboration with psychiatry.

12. Continue and expand the utility of meetings of the polypharmacy review committee.

13. Review the method of reporting polypharmacy data for accuracy and completeness.

14. Increase the frequency of the pharmacy quarterly drug regimen reviews to monthly in order to meet the requirements of the Settlement Agreement.

15. Improve physician documentation of the rationale for the prescription of specific medications as well as for the rationale and potential interactions when polypharmacy is implemented.

16. Improve documentation of psychiatric review and clinical use of DISCUS and MOSES examination results.

17. Ensure that DISCUS and MOSES exams are performed in the appropriate time frames.

18. Improve psychiatric documentation to include a diagnostic formulation and justification for each specific diagnosis.

19. Review the target behavioral data for each individual to determine if appropriate data points are being collected. In order for the data to be usable, it should be graphed with medication information (i.e., start dates of medication, stop dates of medication, and dosage adjustments) included.

20. Ensure that the indications for specific medications correspond to the purported diagnosis, and that appropriate defined behavioral/symptom data points are being monitored.

21. Individualize the process for Informed Consent.

22. Develop a statewide Informed Consent Policy and Procedure that is consistent with Texas law and generally accepted practice of medicine.

23. Explore options to increase the availability of neurology consultation.

The following are offered as additional suggestions to the facility:

24. Consider monitoring the psychiatrist's workload in order to objectively determine the need for additional clinical contact hours. This can better be performed once a baseline is established for meetings/clinical coordination with other disciplines.

25. Develop a recruitment/retention plan for psychiatry. Once sufficient psychiatry staff is in place, consider the designation of a lead facility psychiatrist. Given the location of the facility, it is possible that they will experience difficulty in the recruitment of permanent psychiatric staff. As this creates the likelihood of frequent physician turnover, the facility should consider the development of a "pearls" book. This would be an information book for psychiatry that outlines information that is specific to the practice of psychiatry within the facility, and ease the transition for both the physician and staff.

26. Consider the utilization of scales and screeners normed for this population in an effort to obtain objective data regarding symptoms as well as to monitor symptom response to targeted interventions.

27. Consider the designation of a "parliamentarian" for psychiatric clinic.

28. Consider making the identification of the individual's legal status and the identify/contact information of their legally authorized representative (if any) part of the regular demographic information included in the psychiatric assessment and progress notes. This will make the informed consent process and the regular contact of families/legal representatives during treatment a simpler process.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Positive Behavior Support Plans for: • Individual #14, Individual #488, Individual #183, Individual #280, Individual #507, Individual #506, Individual #360, Individual #586, Individual #248, Individual #306, Individual #179, Individual #163, Individual #327, Individual #433, Individual #559, Individual 377, Individual #283, Individual #400, Individual #520, Individual #51, Individual #98, Individual #110, Individual #519, Individual #481, Individual #458, Individual #452, Individual #105, Individual #89, Individual #448, Individual 408, Individual #6, Individual #251, Individual #281, Individual #270, Individual #271, Individual #398, Individual #535, Individual #422 o Positive Behavior Support Progress notes for: • Individual #535, Individual #433, Individual #448, Individual #89, Individual #398, Individual #183, Individual #488 o Functional Assessments for: • Individual #89, Individual #214, Individual #306, Individual #488, Individual #422, Individual #535, Individual #448, Individual #248, Individual #271, Individual #179, Individual #163, Individual #327, Individual #270 o Psychological Evaluations for: • Individual #5, Individual #502, Individual #329, Individual #26, Individual #218, Individual #275, Individual #196, Individual #448, Individual #488, Individual #240, Individual #284, Individual #407, Individual #535, Individual #433, Individual #89, Individual #579, Individual #265, Individual #312, Individual #1, Individual #100, Individual #203, Individual #185, Individual #534, Individual #336, Individual #398, Individual #183 o Staff training sheets for: • Individual #152, Individual #398, Individual #159, Individual #360, Individual #506, Individual #507, Individual #280, Individual #199, Individual #533, Individual #509, Individual #79, Individual #169, Individual #522, Individual #477 o A spreadsheet of all Psychology Department Staff (dated 8/10) o A spreadsheet of each psychologist's degree, licenses, certifications and BCBA coursework completed (undated) o A spreadsheet of all individuals at MSSLC, admission date, and date of last psychological evaluation, dated 8/20/10 o A spreadsheet of Initial Psychological Evaluations (IPE), undated o A spreadsheet of individuals with structural and functional assessments, dated 9/14/10 o A spreadsheet of Individuals with a PBSP, undated

	Interviews and Meetings Held: o Charlotte Kimmel, Ph.D., Director of Psychology o Lupita Alfano, Psychology Assistant o Chris Christensen, Associate Psychologist III o Psychology Department staff Observations Conducted: o Psychiatry Clinic • Staff Present: - Dr. Kendrick, Psychiatrist; Mauanna Echols, QMRP; Donna Porter, Psychologist; Terri Moon, QA auditor; Natalie Hamilton, RN • Individuals Presented: - Individual #434, Individual #159 o Psychiatric Clinic • Staff Present: - Dr. Farber, Psychiatrist; Michael Grimmett, Psychologist; Shericka Phillips, DCP, Angela Johnson, RN; Regina Bauaza, QMRP; Lupita Alfaro, Psychology Assistant; Terri Moon, QA Auditor • Individual Presented: - Individual #407 o Behavior Therapy Committee Meeting • Staff Present: - Charlotte Kimmel, Director of Psychology Services; Michael Grimmett, Psychologist; Molly Chase, Psychologist; Amy Diller, BCBA Consultant; Judy Haynes, Psychology Secretary; Mark Richards, Assistant Director of Psychology; Valerie McGuire, QMRP Director; Alan LaGrone, Psychiatrist; Deborah Grimmett, Psychologist; Donna Porter, Psychologist; Michael Miller, Psychologist; Chris Christensen, Psychologist; Andrew Griffin, Psychologist • Individuals Presented: - Individual #408, Individual #105, Individual #481, Individual #519, Individual #6, Individual #452, Individual #458, Individual #586, Individual #51, Individual #281, Individual #283, Individual #251, Individual #400, Individual #96, Individual #559, Individual #377 o Observations occurred in various day programs and residences at MSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training), and • Implementation of behavior support plans

	Facility Self-Assessment: MSSLC's Plan of Improvement (POI) indicated noncompliance for each item of this settlement provision. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's POI findings of noncompliance in all areas. The only exception was provision item K2 (qualified director of psychology) which the monitoring team determined was in substantial compliance with the Settlement Agreement. The POI established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur in the way psychology services are provided, and because it will likely take some time for MSSLC to make these changes, it may be useful for the facility to also establish short-term goals (e.g., for the next six months) so that the psychology staff can better mark their progress toward substantial compliance.
	Summary of Monitor's Assessment: Although only one of the items in this provision was found to be in substantial compliance with the Settlement Agreement, progress was observed in several items. These areas of improvement since the baseline review were: • Several psychologists were enrolled in coursework to become certified in applied behavior analysis (BCBA), and several other staff were approved (or were in process of seeking approval) to sit for the BCBA national exam. Finally, a consulting BCBA was hired to supervise and offer technical support to staff in the BCBA program (K1) • Improvements in data collection (K4) • Progress was made toward ensuring that psychological therapies were evidence-based, and goal directed with measurable objectives (K8) There were also areas that the monitoring team believed required immediate attention. Those areas included: • A plan needed to be developed to ensure that those psychologists not enrolled in BCBA coursework, or eligible to sit for the exam, received the training and experience necessary to write effective positive behavior support plans (K1) • The new data system needed to be expanded to all homes and day sites, the types of data collected needed to be expanded, and interobserver agreement needed to be consistently assessed and tracked (K4) • Many components of a functional peer review system existed at MSSLC, however, peer review needed to be expanded to include an opportunity for staff psychologists to present and discuss individual treatment plans beyond those requiring administrative approval (K3) • The facility needed to clarify what behavior procedures can and cannot be used at MSSLC

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because the psychologists were not yet demonstrably competent in applied behavior analysis (ABA) as evidenced by the absence of professional certification, and the overall quality of the positive behavior support plans (PBSPs) at the facility (see K9). At the time of the onsite tour, two of the facility's psychologists had been approved to sit for the board certified behavior analyst (BCBA) exam, and three psychologists were enrolled in course work toward becoming BCBAs. Three additional psychologists were seeking eligibility to sit for the BCBA exam based on training and experience. Additionally, a consulting professional with expertise in ABA and certified as a BCBA was recently hired to assist in the development of PBSPs, and to provide supervision of facility psychologists enrolled in the BCBA program. MSSLC and DADS are to be commended for their efforts to recruit and to train staff to meet the requirements of this provision item. The facility had developed a spreadsheet to track each psychologist's BCBA training and credentials. It is recommended that the facility develop a plan to ensure that the remaining psychologists attain BCBA certification.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility has attained substantial compliance with this item. MSSLC employed a Director of Psychology with a Ph.D., certification in sex offender treatment and forensic evaluations, and over 30 years experience working with individuals with intellectual disabilities. Supervisees interviewed indicated they had positive professional interactions with, and received professional support from, Dr. Kimmel. Finally, under Dr. Kimmel's leadership, several initiatives have begun (e.g., increased number of psychologists enrolled in BCBA coursework, hiring of a BCBA consultant, modifications in the data system, introduction of evidence-based therapies) leading toward the attainment of compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	This item was rated as being in noncompliance because the internal peer review consisted of only annual reviews of PBSPs. During the Behavior Therapy Committee (BTC) meeting observed by the monitoring team, there was active discussion and several examples of staff sharing strategies and suggestions to improve PBSPs. The BTC meetings, however, only reviewed cases that required annual approval of PBSPs or safety plans, or contained modifications that	Noncompliance

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		required approval. Missing from the BTC was the opportunity to present cases that were not progressing as expected. It is recommended that peer review meetings be extended, from just annual reviews, to include any case that a psychologist (or his or her supervisor) believes would benefit from the input of other psychologists. This could be accomplished by adding a specific weekly peer review meeting, or expanding the BTC meetings to include the review of challenging cases. At the time of the onsite review, the facility was conducting what it called external peer review by having the BCBA consultant attend BTC/peer review meetings. This was great to see, but really should be considered to be part of the internal peer review process because this consultant helped oversee and develop the facility's PBSPs. Therefore, this would not be considered to be external peer review. External peer review involves review by other professionals who are not directly responsible for the development and implementation of the PBSP, such as external peer review by other Texas DADS BCBAs and supervisors (perhaps by teleconference). Operating procedures for both internal and external peer review committees will need to be established.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The data collection methodology used at MSSLC did not conform to ABA generally accepted professional standards and, therefore, this provision item has been rated as being in noncompliance. Several psychologists indicated that they did not have confidence in the data that was collected by the direct care professionals (DCPs). Additionally, the monitoring team noted several examples of treatment decisions that were not based on available data. For example, Individual #434 was reported to be doing substantially better at a psychiatry clinic attended by the monitoring team. Individual #434's data, however, indicated that her undesired behaviors were increasing, not decreasing. When the monitoring team pointed out the discrepancy in what the psychologist was saying with the available data, the psychologist simply concluded that the data must be inaccurate, and the team's discussion continued around Individual #434's perceived behavioral improvements. Since the baseline review, however, the facility had improved its data collection by introducing a simplified, hourly data collection system in some of the residential units (i.e., Martin, Shamrock, and some of the homes in Whiterock). This change has resulted in the two psychologists in Martin indicating more confidence in their data, and the DCPs in those homes reporting that data were easier to record. It is recommended that this simplified hourly data collection system be expanded to all of the homes at MSSLC. The data system also needs to be more sensitive to each individual's needs. That is, in addition to being simpler for DCPs to collect, the data system needs to be able to accurately assess both behaviors that occur at low rates, as well as behaviors that occur	Noncompliance

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		at very high rates (e.g., stereotypes, undesirable verbal behavior). Depending on the target behavior and its frequency, the facility should use a range of measures, such as frequency, time sampling, and duration measures. It is recommended that the facility expand its data collection system to allow it to accurately assess the occurrence of all target and replacement behaviors. None of the DCPs interviewed indicated that they had input in the establishment of data collection systems. It is recommended that DCP input in data system development be sought and documented. The use of hourly data lends itself to the assessment of treatment integrity, and increases accountability by allowing psychologists and supervisors to immediately determine if data has been collected (see discussion in the next paragraph). In those residential units with the new data system, DCPs were expected to document the frequency of target behaviors or desired alternative behaviors each hour. The expectation was that each time block (every hour), should have the occurrence of target or alternative behaviors documented. Blank hourly slots indicated noncompliance of the DCP's data collection duties. It is possible, however, that some time slots may not contain a target or alternative behavior. In those situations the DCPs are left with the choice of indicating one of those behaviors occurred (even if it didn't), or appear to be noncompliant. It is recommended that DCPs be provided the option to record a zero in the time slot if no target or replacement behaviors occurred. The monitoring team sampled compliance with the new data system in three homes in Shamrock (S1, S3, and S4). All hourly time blocks in S3 and S4 were completed for the day of the review, and the two days prior to the review. Several blocks were empty, however, for Individual #89, Individual #332, and Individual #578's data sheets in S1. The DCPs in S1 could not explain why the data blocks were empty. It is recommended that the unit psychologist (or psychology assistant) regularly conduct similar integrity checks to assess and improve the integrity of recording of target and replacement behaviors in each home and day/vocational site. The addition of these checks (which assess that data are recorded), along with interobserver agreement data (which assess if multiple people agree that a target or replacement behavior occurred) represent the most direct methods for assessing and improving the integrity of collected data. It is recommended that the facility begin the collection of interobserver agreement (IOA) data for all target and replacement behaviors in each residential and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained, or data systems modified, if scores fall below those targets. Target behaviors were analyzed individually. At the time of the onsite tour, target and replacement behaviors were graphed monthly, that is, each datum point represented one	

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		month of data. Some behaviors, however, need to be graphed more frequently to ensure that sufficient data-based decision making can occur. Monthly data points, for example, would not allow one to identify the effects of a new medication or change in the PBSP for several months. A more sensitive graph (i.e., each datum point representing weekly or even daily data) that identifies behavioral trends quickly could assist the psychiatrist or psychologist in the most effective use of a medication or treatment intervention. For example Individual #535's behavior therapy progress note of 7/16 /10 indicated that he had 13 medication changes in 10 days. Because his undesired behaviors were graphed as one datum point per month, it was impossible to determine the effects of any one medication change on the target behavior. On the other hand, if Individual #535's target behaviors were graphed in daily intervals (during this period of rapid medication change), and the changes in medication were indicated on the graph, it would have been possible to evaluate the effects of any single medication on his target behaviors. It is recommended that MSSLC graph target and replacement behaviors at intervals sufficient to make data-based treatment decisions. The monitoring team identified a few examples of PBSPs being modified prior to the annual review due to an increase in target behaviors (i.e., Individual #6 and Individual #578). The majority of PBSP data reviewed, however indicated an increase (e.g., Individual #488, Individual #89, Individual #448, Individual #535) or no change (e.g., Individual #433) in serious target behaviors such as physical aggression, with no modification in the PBSPs prior to the annual review. It is important that when individuals' data trends in an undesirable direction (or continues with no improvement), that hypotheses be developed, changes be made to the PBSP, and that these changes be documented in the progress notes. A criterion for revision of the plan was not included in the PBSPs. A specific and individualized criterion for review of each PBSP should be established, and the decision to revise should be based upon the data.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of psychological assessments and functional assessments for many individuals at MSSLC, and the lack of comprehensiveness of these documents. <u>Psychological Assessments</u> The majority of new admissions at MSSLC were court ordered under Texas's Family Code Sec. 55.33 for juveniles or Code of Criminal Procedures 46B.073 for adults. The requirement for these assessments is (a) an assessment of mental retardation and, (b) a determination of legal competence. The purpose and content of these court ordered assessments was presented in the baseline report, and will not discussed in greater detail in this report.	Noncompliance

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		Although psychological evaluations were evident for the majority of individuals, a spreadsheet of all individuals and date of last psychological evaluation indicated that approximately 65 individuals had no documented psychological assessment. The facility had recently begun to conduct standardized initial psychological evaluations (IPEs) and had completed those for approximately 57 individuals. A review of completed IPEs indicated that they contained a review of the individual's intellectual ability, an assessment of adaptive ability, and a review of personal history. There was no screening for psychopathology or assessment or review of biological, physical, and medical status. The facility, however, indicated that Reiss screens were now beginning to be completed on new admissions and individuals currently at the facility. Each individual's record should contain a psychological assessment that consists of an assessment of intellectual ability, adaptive ability, and biological (or physical) status. Additionally, the assessment should include a personal history as well as a screening for psychopathology and behavioral issues (or a summary of a full psychiatric assessment, if one had been completed for the individual). <u>Functional Assessments</u> A spreadsheet of all individuals with a PBSP provided to the monitoring team indicated that approximately 315 individuals at MSSLC had a PBSP. Only 96 of those individuals, however, had a functional assessment. All individuals whose records indicated a behavioral disturbance should have a functional assessment of the variable or variables affecting the individual's target behaviors. It is recommended that all functional assessments use a format that includes the following components. Since the functional assessments and the PBSPs were generally presented together, these components could be included in either the functional assessment or PBSP: • Direct and indirect measures of targeted behaviors reflecting a process or instrument widely accepted by the field of applied behavior analysis • Differentiation between learned and biologically based behaviors • Identification of setting events and motivating operations relevant to the undesired behavior • Identification of antecedents relevant to the undesired behavior • Identification of consequences relevant to the undesired behavior • Identification of functions relevant to the undesired behavior • Identification of functionally equivalent replacement behaviors relevant to the undesired behavior • Summary statements identifying the variable or variables maintaining the target behavior	

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		• Identification of functionally equivalent replacement behaviors • Identification of preference and reinforcers Of the 13 functional assessments provided to the monitoring team, 10 were developed or revised since the baseline review. The majority of the functional assessments reviewed included most of the above necessary assessment tools and components. The comprehensiveness and quality of many of the above components, however, was not adequate and therefore many of the functional assessments reviewed were not considered useful for understanding the target behaviors. The following are representative examples. All of the functional assessments reviewed included indirect and direct measures. In eight of the functional assessments reviewed the target behaviors were not, however, included in the direct assessments. For example: • Individual #248's direct observation stated "….was observed directly by psychology staff on the home, during STOP group, and at leisure time and no problem behaviors were noted during the observation periods." Although this was a direct observation of the individual, it did not include direct observation of any of the target behaviors and, therefore, it was not possible to better understand the target behaviors from this observation. Several other functional assessments (e.g., Individual #306, Individual #270) included excerpts from observations notes recorded by staff. These tended to not be useful examples of a direct functional assessment because it was difficult to identify behavioral patterns, and there was no attempt to summarize them. The facility should conduct direct observations until the target behaviors occur. Additionally, the results of direct functional assessments should be summarized. Although unstructured observations for Individual #535 and Individual #448 clearly identified potential antecedents and consequences of target behaviors, the monitoring team suggests that the facility consider the use of some structured direct assessments, such as ABC sheets. All of the functional assessments reviewed identified setting events relevant to the undesired behavior. Some of the identified setting events of target behaviors, however, were not operationally defined and, therefore, not useful for understanding the variables maintaining the behavior. For example: • Individual #248's functional assessment hypothesized the setting events of his target behaviors was when Individual 248 was angry or upset. Although it was certainly possible that Individual #248's verbal and physical aggression only occurred when he was angry or upset, in order to better understand the setting	

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		events that are associated with his target behaviors, it would be important to also know what environmental conditions resulted in him becoming upset or angry (e.g., not getting his way, loud noises). All of the functional assessments reviewed included a section for summarizing the overall results of the functional assessment, however, many functional assessments reviewed did not provide a summary of the variables maintaining the target behavior in this section (e.g., Individual #327, Individual #163, Individual #271, Individual #535), or the summary statement did not appear to be consistent with the reported results. For example: • Individual #448's summary statement indicated that his self-injurious behavior (SIB) occurred when she cannot get her way. Her indirect assessment indicated, however, that her SIB was automatically maintained. In fact, there was no indication in the functional assessment that this behavior had a social function. All functional assessments reviewed included a list of preferences and reinforcers for each individual. These preferences and reinforcers, however, were not consistently used therapeutically. For example, Individual #89's PBSP specified providing him with praise and social attention following desirable behavior. Praise and social attention, however, were not included as Individual #89's preferences. In fact, his functional assessment indicated that social interactions were often not tolerated by him. Praise and staff attention may not be reinforcers for every individual. If staff surveys do not identify practical and potent preferences, a systematic preference assessment should be conducted. Finally, there were several functional assessments (e.g., Individual #458, Individual #327, Individual #306, and Individual #89) where the term motivating operation was used incorrectly. Motivating operations are events that alter (i.e., increase or decrease) the reinforcing effectiveness of a stimulus, object, or event. For example, if an individual is hypothesized to engage in disruptive behaviors in order to obtain staff attention, the value or effectiveness of attention could be reduced if attention is provided frequently in the absence of disruptive behavior. Many of the functional assessments reviewed appeared to confuse setting events with motivating operations. The functional assessments reviewed did not contain replacement behaviors, however, replacement behaviors were included in all of the PBSPs reviewed. Replacement behaviors should be functional. That is, they should represent desired behaviors that serve the same function as the undesired behavior. For example Individual #327's targeted behaviors were hypothesized to be maintained by positive attention. His replacement behaviors included teaching him to ask for staff attention. This was a good example of a functionally equivalent replacement behavior because it provided the same	

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		reinforcer (i.e., attention from staff) as hypothesized to be maintaining the target behavior. Many of the replacement behaviors reviewed, however, did not appear to be related to the function of the target behavior. For example: • Individual #306's replacement behaviors consisted of participation in programming. These may be important skills and activities for Individual #306, however, they are not functionally equivalent to the purposed function of his target behaviors: staff attention. • Replacement behaviors for Individual #488 were cooperative participation in activities of daily living. Her target behaviors, however, were hypothesized to be maintained by escape of undesirable activities. A functional replacement behavior would be represented by allowing Individual #488 to escape some tasks for requesting a break, or to escape the remainder of a task by completing some of it. None of the PBSPs reviewed included specific instructions for how to train replacement behaviors. Some of the replacement behaviors were not operationally defined and it would likely be difficult for DCPs to teach the behaviors without additional instruction. For example, Individual #520's replacement behavior consisted of being respectful toward others. Examples of respectful behavior were included, however, some examples, such as "responding politely to reasonable requests by others," would not likely be interpreted by all DCPs the same way, resulting in inconsistent implementation of the replacement behavior. It is recommended that all replacement behaviors include specific skill acquisition plans for training. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility. These plans should be based upon a task analysis (when appropriate), have behavioral objectives, contain a detailed description of teaching conditions, and include specific instructions for how to conduct the training and collect data (see section S1 of this report). There was no evidence that functional assessments at MSSLC were reviewed and modified when an individual did not meet treatment expectations. It is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that it be included in a revision of the functional assessment. Additionally, functional assessments should be reviewed at least annually to ensure accuracy.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that	MSSLC's psychological assessments were not based on current, accurate, and complete clinical and behavioral data (see K5 and K7) and, therefore, this provision item was rated as being in noncompliance.	Noncompliance

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	psychological assessments are based on current, accurate, and complete clinical and behavioral data.		
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	As indicated in K5, psychological assessments were not completed for every individual at MSSLC and, therefore, this provision item was rated as being in noncompliance. The facility should conduct psychological assessments as needed, and at least every five years, for each individual residing at the facility. Additionally, the monitoring team recommends that each individual at the facility receive an annual psychological assessment update. The purpose of the annual update would be to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update would comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year. The facility was doing a good job of ensuring that new admissions receive psychological assessments within 30 days. The initial psychological evaluation (IPE) log indicated that 10 individuals were admitted to MSSLC from 6/8/10 to 7/20/10. Nine of these individuals had initial psychological assessments within 30 days. The remaining individual received his psychological assessment in 31 days following his admission.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	Psychological services, other than PBSPs were provided at MSSLC. At the time of the onsite review, the facility was beginning to incorporate evidence-based procedures with measurable objectives and treatment expectations into these services. More work in this area, however, is needed to be done before this provision item can be considered to be in substantial compliance. Some of the recent psychological assessments reviewed (e.g., Individual #240's assessment) did document the need for psychological services other than PBSPs. The need for psychological services other than PBSPs was not documented in the psychological assessments for all individuals receiving psychological services. It is recommended, that for individuals receiving psychological services, that the need for these services is documented in every individual's psychological assessment. At the time of the onsite review, MSSLC provided several group therapies including, Specialized Treatment of Pedophilias (STOP), Substance Abuse Treatment Program (SATP), Licensed Sex Offender Treatment Provider (LSOTP), Physical and Sexual Abuse Survivor (PSAS), and Anger Management groups. Additionally, the facility offered individual therapy. A new anger management evidence-based curriculum was begun in	Noncompliance

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		August of 2010. The above therapies were provided by a qualified staff (i.e., a psychologist with a degree in counseling). According to a list submitted by the facility, 141 individuals received one of these psychological services, but no individual received more than one of these services. The treatment plans for 17 of these individuals were submitted by the facility and were reviewed. All included a purpose and plan, but did not meet the criteria listed below. Thus, the facility made progress toward providing evidence-based psychological services. Subsequent monitoring tours will review these service to ensure that: • They contain a treatment plan that includes an initial analysis of problem or intervention target • Services are goal directed with measurable objectives and treatment expectations • Services reflect evidence-based practices • Services include documentation and review of progress • The service plan includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • The service plan includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a	This item was rated as being in noncompliance because the quality of the content of some of the PBSPs reviewed did not meet the generally accepted professional standard of care, and because there was no evidence that the interventions were consistently based on functional assessment results and on-going individual behavior. All of the PBSPs reviewed had the necessary consents and approvals. Of the 38 PBSPs reviewed, 27 were completed or updated since the baseline tour. There are several important components that should be included in every PBSP. Because the PBSPs and functional assessments were generally presented together, the monitoring team looked at both of these documents to determine if the following components were present. All of PBSPs and/or functional assessments reviewed included: • Rationale for selection of the proposed intervention. • History of prior intervention strategies and outcomes. • Consideration of medical, psychiatric and healthcare issues. • Operational definitions of target behaviors. • Operational definitions of replacement behaviors. • Description of potential function(s) of behavior. • Use of positive reinforcement sufficient for strengthening desired behavior.	Noncompliance

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	written extension based on extraordinary circumstances.	• Strategies addressing setting event and motivating operation issues. • Strategies addressing antecedent issues. • Strategies that include the teaching of desired replacement behaviors. • Strategies to weaken undesired behavior. • Description of data collection procedures. • Baseline or comparison data. • Signature of individual responsible for developing the PBSP. Although present in all PBSPs/functional assessments reviewed, the quality of some of the above components appeared insufficient for the plans to be as effective as they could be. The following examples were typical: • Many operational definitions of target behaviors were not clear or operational. For example Individual #559's aggression was defined as "any act that has the potential to injure another person…" This definition is not complete. It leaves too much interpretation of what aggression is to the DCP recording the behavior. One DCP, for example may interpret spitting as having a potential to injure another person, where another may not. Similarly, one of Individual #433's targeted behaviors was rage reaction. The definition included "… exhibiting behaviors while angry which might harm others." Some operational definitions required the reader to determine the individual's intentions. For example, Individual #89's target behavior of physical aggression included "...bullying, intimidating others…" These definitions of target behaviors required the reader to infer the intent of the individual. Operational definitions, however, should not require the reader to infer intent, they should consist of objective behaviors that are clear and complete. Finally, the operational definitions for some individuals sounded very similar. For example, the operational definition of aggression was the same for Individual #163, Individual #327, Individual #179, and Individual #248. Operational definitions should be individualized. On the other hand, the facility has done an excellent job in reducing the number of undesired target behaviors included in each PBSP. Conversations with staff, observations in meetings (i.e., BTC meeting), and review of PBSPs written since the baseline review, all indicated that the number of target behaviors were reduced to two or three; a number that DCPs were more likely to reliably record. • All of the PBSPs reviewed included a description of potential functions of undesired behavior, however, some were not useful for decreasing the behavior. For example, the description of the potential function of Individual #89's physical and verbal aggression was described as "frustration stemming from a lack of control over his environment…" Saying a behavior is the result of frustration does not, however, help us to better understand the behavior. In order to eliminate aggression, we need to understand why Individual #89	

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		becomes frustrated and engages in verbal or physical aggression. That is, it is important to identify the variable or variables that frustrate Individual #89 and result in aggression. Concluding that a behavior is maintained by frustration is not a useful description of the function of the behavior. The more useful question (for developing effective treatment interventions) is what are the antecedent and consequent events that result in him becoming frustrated and aggressive (see K5)? • The problems associated with the operational definitions and teaching strategies of replacement behaviors were discussed in detail in K5. • Although all PBSPs reviewed included strategies for weakening undesired behaviors, many appeared likely to have the opposite effect. For example, Individual #488's PBSP indicated that her undesirable behavior was maintained by avoiding unpleasant activities. The intervention following undesired behavior, however, directed staff to encourage her to sit in a quiet area. If the function of the behavior was in fact negative reinforcement (i.e., escaping/avoiding unpleasant activities), then this intervention would likely increase physical aggression because it allowed Individual #488 to escape activities by engaging in an undesired behavior. On the hand, a potential intervention based on these functional assessment results, might include having her return to the previous activity (not allowing her to escape the undesired event), and allow her to get breaks from, or avoid, certain activities by indicating (in a more socially acceptable manner than aggression) that she did not want to engage in the activity. Similarly, Individual #163's PBSP indicated that aggression was maintained by staff attention. The intervention included staff helping him resolve the problem when he began to get upset. Again, if the functional assessment is accurate and his aggression is maintained by staff attention, then this procedure would serve to increase his disruptive behavior by providing staff attention following the undesired behavior. Finally, Individual #214's PBSP to decrease self-injurious behavior (SIB) included telling him to stop and if he did, "…provide him some food and liquids as permitted by his diet texture." If food and liquids are reinforcers (as indicated in the plan), then this intervention should result in an increase in Individual #214's SIB. • All of the PBSPs reviewed included the use of positive reinforcement to strengthen desired behavior. Additionally, all of the PBSPs reviewed included a list of preferences for each individual. It did not appear, however, that the most potent reinforcers were consistently used. For example, Individual #89's PBSP specified that he should be praised for following his diet. Praise, however, was not included as a reinforcer in his list of reinforcers/preferences, or anywhere else in his PBSP. Food, on the other hand, was reported to be a potent reinforcer for Individual #89 (and getting food was hypothesized to be the source of much	

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		of his undesirable behavior). Additionally, his list of preferences/reinforcers indicated that several foods, such as sugar free candy, saltine crackers, and so forth were both highly preferred and allowed by his diet. Reinforcers should be chosen because they have been identified as highly preferred and are practical to use. Staff attention, or being praised by staff, is not a reinforcer for all individuals. For some, in fact, staff attention or praise could be aversive. It is recommended that MSSLC ensure that items used as reinforcers do in fact function as reinforcers. One way to increase the chances that an event functions as a potent reinforcer is to use an event that is functionally equivalent to the event that is maintaining the undesired behavior. For example if Individual #89's undesirable behavior is hypothesized to be maintained by his attempt to gain food, then food (that is allowed by his diet) is likely to be a very potent reinforcer for desirable behavior, or the absence of the undesired behavior. Examples of functionally equivalent reinforcers for individuals whose target behaviors were maintained by attention were apparent in the PBSPs reviewed. For example, Individual #520's PBSP hypothesized that his verbal aggression was maintained by others' attention. His PBSP specified the reduction of attention (i.e., use of local time out) following verbal aggression, and specified praise and attention when Individual #520 attempted to attain attention in a positive manner. Similarly, providing an opportunity to avoid or escape a task/event following desired behavior (e.g., asking for a break, completing a portion of the task) can be a very potent reinforcer for an individual whose undesired behavior is maintained by negative reinforcement (i.e., escape or avoidance of selected events/task). It is recommended that the facility attempt to more consistently use functionally equivalent reinforcers in PBSPs for individuals whose undesired behaviors are maintained by negative reinforcement or access to tangibles. As discussed in K4, PBSPs were not consistently modified based on ongoing individual behavior (see K4). Finally, many of the psychologists indicated that they felt their PBSPs were not as effective as they could be because they were not allowed to use procedures, such as response costs, level systems, or differential reinforcement. Many of those interventions, however, appeared in the 38 PBSPs reviewed by the monitoring team. It was unclear to staff what procedures the facility allowed and which were prohibited. It is suggested that the facility develop a list of procedures that can be used, the conditions necessary to implement them (e.g., HRC permission, guardian consent, director of psychology review, etc.), and a list of specific procedures that are prohibited by the facility.	

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K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Interobserver agreement measures were not collected for target and replacement behaviors at the time of the onsite tour (see K4). A system to regularly assess the accuracy of PBSP data is a necessary requirement for determining the efficacy of treatment and for meeting the requirement of this provision item. PBSP data were consistently graphed monthly at MSSLC. As discussed in K4, however, these data should be graphed and presented in increments that would be sensitive to individual needs and situations (e.g., daily or weekly graphed data to assess the changes associated with a change in medication or target behaviors). The graphs reviewed contained a horizontal and vertical axis and labels, condition change lines and label, data points, and a data path. They did not contain clear demarcation of changes in medication, health status, or other relevant events.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	This provision item was rated as being in noncompliance because the facility, at the time of the onsite tour, did not track treatment integrity data. All staff interviewed indicated that they understood each individual's PBSP. Additionally, staff were able to explain how they would implement an individual's PBSP. For example, a DCP on C7 working with Individual #6 was able to explain to the monitoring team how she would respond if Individual #6 engaged in aggressive behavior. Similarly a DCP working on W8 with Individual #99 was able to explain how he would respond to several target behaviors. Further observations of DCPs implementing PBSPs also appeared to be consistent with written plans. The only way to ensure, however, that PBSPs are implemented as written is to implement a system to systematically monitor treatment integrity. It is recommended that a treatment integrity system be developed, data regularly tracked, and minimal acceptable integrity measures be established. Since the baseline tour, MSSLC had begun a process of reviewing each PBSP and attempting to eliminate unnecessary target behaviors (see K9), and simplifying the interventions. This process has resulted in more practical and useful PBSPs that are more likely to be implemented with integrity by DCPs.	Noncompliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their	The psychology department maintained logs documenting each DCP that had been trained on each individual's PBSP. The trainings were conducted by psychologists and psychology assistants prior to PBSP implementation and whenever plans changed. The trainings consisted of presentations to DCPs, followed by a paper and pencil	Noncompliance

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	supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	assessment. The trainings did not, however, include a competency-based component. Additionally, there was no system in place to ensure that all staff (including relief staff) had been trained. Finally, there was no systematic way to identify all of the staff who required remedial training. Therefore, this item is rated as being in noncompliance. In order to meet the requirements of this provision item, it is recommended that the staff training procedures include a competency-based component, and the development of a centralized system to ensure that all staff are trained in the implementation of each individual's PBSP.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite tour, MSSLC had a census of 416 individuals and employed 21 psychologists and 10 psychology assistants. None of the psychologists, however, had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have 14 psychologists with BCBAs.	Noncompliance

Recommendations:

1. Continue with training and supervision of psychology staff towards obtaining the BCBA certification.
2. The facility should develop a plan to ensure that the remaining psychologists attain BCBA certification.
3. Peer review meetings should be extended, from exclusively annual reviews, to include any case that a psychologist (or his or her supervisor) believes would benefit from the input of other psychologists.
4. Operating procedures for both internal and external peer review committees need to be established.
5. The hourly data collection system should be expanded to all of the homes at MSSLC.
6. The facility should expand its data collection system (e.g., duration measures, time samples, etc.) to allow it to more accurately assess the occurrence of all target and replacement behaviors.
7. It is recommended that DCP input in data system development occur and be documented.
8. It is recommended that DCPs be provided the option to record a zero in the hourly time slot if no target or replacement behaviors occurred.

9. The facility should conduct regular data collection integrity checks to assess and improve the integrity of recording of target and replacement behaviors in each home and day site with the new hourly data collection system.

10. MSSLC should begin the collection of interobserver agreement (IOA) data for all target and replacement behaviors in each residential and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained, or data systems modified, if scores fall below those targets.

11. It is recommended that target and replacement behaviors be graphed at increments sufficient to make data-based treatment decisions.

12. When individuals' data trends in an undesirable direction (or continues with no improvement), hypotheses should be developed, and changes should made to the PBSP.

13. A specific and individualized criterion for review of each PBSP should be established, and the decision to revise should be based upon the data.

14. Each individual's record should contain a psychological assessment that consists of a personal history, assessment of intellectual ability, adaptive ability, biological (or physical) status, and a screening for psychopathology (or a summary of a full psychiatric assessment, if one had been completed for the individual).

15. All individuals whose records indicated a behavioral disturbance should have a functional assessment of the variable or variables affecting the individual's target behaviors.

16. The facility should conduct direct observations that include the target behaviors. The conclusion of the direct assessment should be summarized.

17. It is recommended that all replacement behaviors include specific skill acquisition plans for developing replacement behaviors. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility.

18. Functional assessments should be reviewed at least annually, and when the individual does not meet treatment expectations.

19. The facility should conduct psychological assessments as needed, and at least every five years, for each individual residing at the facility.

20. If psychological services other than PBSPs are provided, it is recommended that need for psychological services be documented in every individual's psychological assessments.

21. Psychological services, other than PBSPs, should include:
    - A treatment plan that includes an initial analysis of problem or intervention target
    - Services that are goal directed with measurable objectives and treatment expectations
    - Services that reflect evidence-based practices
    - Services that include documentation and review of progress

- A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention
- A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings

22. Definitions of target behaviors need to be clear, complete, and operational.

23. Operational definitions should be individualized.

24. All items used as reinforcers should be demonstrated to function as reinforcers.

25. It is recommended that the facility attempt to more consistently use functionally equivalent reinforcers in PBSPs for individuals whose undesired behaviors are maintained by negative reinforcement or access to tangibles.

26. It is recommended that a treatment integrity system be developed, and data tracked.

27. DCP training procedures should include a competency-based component, and the development of a centralized system to ensure that all staff are trained in the implementation of each individual's PBSP.

28. It is suggested that external peer review be extended to other Texas DADS, BCBAs and supervisors (perhaps by teleconference).

The following are offered as additional suggestions to the facility:

29. In addition to the long-term POI goals, it may be useful for the psychology department to establish short-term goals (e.g., for the next six months) so that the psychology staff can better mark their progress toward substantial compliance.

30. It is suggest that the facility consider the use of some structured direct assessments such as ABC measures.

31. It is suggested that the facility develop a list of procedures that can be used, the conditions necessary to implement them (e.g., HRC permission, guardian consent, director of psychology review, etc.), and a list of specific procedures that are prohibited by the facility.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #009: Medical Care, dated 7/20/10 o MSSLC Home Life and Training Manual, Nursing Services EP-12, Seizure Management, 8/8/08 o Policies and Procedure Manual Medical- 13, Medication Reduction Plan, 12/1/05 o DADS Policy #006: At Risk Individuals, dated 10/5/09 o DADS Policy #09-001 Clinical Death Review, dated 3/09 o DADS Policy #09-002 Administrative Death Review, dated 3/09 o Clinical Death Reviews, Administrative Death Reviews, Physician Death Summaries and Nursing Investigative Reports for eight individuals who died between February 2010 and July of 2010 o Listing, Individuals with seizure disorder o Listing, Individuals diagnosed with pneumonia o Listing, Individuals with diabetes mellitus o Listing, Individuals with osteoporosis o Records of the following 30 individuals: • Individual #299, Individual #161, Individual #355, Individual #455, Individual #113, Individual #134, Individual #470, Individual #570, Individual #278, Individual #111, Individual #249, Individual #86, Individual #281, Individual #533, Individual #326, Individual #70, Individual #104, Individual #344, Individual #583,, Individual #599, Individual #241, Individual #225, Individual #417, Individual #261, Individual #52, Individual #99, Individual #258, Individual #352, Individual #30, Interviews and Meetings Held: o Dolores Erfe, M.D., Medical Director o Christopher Ellis, M.D., Primary Care Physician o Liesl Schott, MD, Primary Care Physician o Gabriel Tarango, D.O., Primary Care Physician o Victor Vines, M.D, Primary Care Physician o Jose Ruiz, M.D, Primary Care Physician o Yenni Michel, D.O. Primary Care Physician o Norris Buchmeyer, R.N., Chief Nursing Executive o Daily medical staff meetings o Health Risk Screening Meeting o Medical staff-nurse liaison meeting Observations Conducted: o Residences

	o Day services areas o Woodshop
	Facility Self-Assessment: The medical department had the ongoing challenge of a staffing structure that consisted largely of temporary physicians. In completion of the self-assessment, the department indicated non-compliance in all areas. In several key areas, the comments were limited to "waiting on direction from state office. " Observations, interviews, attendance at facility meetings, review of policies, procedures and multiple documents have resulted in the monitoring team's finding being congruent with the facility's self-assessment ratings of noncompliance with all provisions items.
	Summary of Monitor's Assessment: The facility was still in the very beginning stages of addressing this provision of the Settlement Agreement. Medical policy had been issued from state office, but the medical director reported that state office had directed the facility to make no changes until further guidance was provided. This resulted in no movement towards substantial compliance in several provision items. The medical staff was comprised of six primary care physicians, a medical director, and three psychiatrists. Five of the six primary care physicians were temporary locum tenens physicians as were all three of the psychiatrists. The medical director did not carry a caseload. It was reported by the medical director that physicians tended to rotate every three months. Four of the six primary care physicians started in July. The PCPs shared a collegial relationship. They participated in daily staff meetings and engaged in weekly working lunches. It was quite evident that they wanted to serve the individuals in the best manner possible. During the week of the onsite review, they attended numerous supplemental and emergency meetings in an effort to overcome what they perceived as barriers to their ability to practice in the best interests of the individuals. It was apparent that training related to issues of rights and protection was not adequately provided. This was most evident in the area of restrictions and differentiating between behavioral and medical restraints. Primary care physicians conducted clinic daily starting around 8:30 am. Each unit had a clinic where individuals were taken to see their physician. A calendar was maintained in each dorm that listed who needed to be seen and the reason for the MD evaluation. Individuals requiring acute care were transferred to local hospitals for evaluation and/or admission. The facility maintained a hospital liaison program through nursing services. The nurse liaison visited the hospitals each morning and provided updates to the medical staff around noon. During observations of the daily PCP meetings, it was clear that the PCPs communicated with the hospital attending physicians.

	The facility maintained a draw station. Labs were routinely sent to Austin State Hospital and results were available the next day. Stat labs were sent to a local hospital and results were available within two to four hours. Basic x-ray studies were completed onsite. The films were picked up by courier and taken to Waco. The films would arrive at the destination facility the next morning. X-ray reports were available online after 36 to 48 hours. All specialty evaluations were done off-site with the exception of podiatry clinic. There was no progress made in implementing a medical quality program. Death reviews were consistently completed at the facility, but these reviews did not include an external reviewer. All deaths reviewed for the year 2010 were attributed to either pneumonia or malignancy. This pattern, as well as the actual mortality review process, requires further assessment by the facility.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	**General Medical Care and Documentation** A sample of records, listed above in the Steps Taken section of this report was reviewed. <u>Annual Assessments</u> Annual assessments were completed based on a standardized format. Components of the assessment included the history of present illness, current diagnoses, past medical history, current medications, allergies, immunizations, physical exam, assessment and plan. The format did not meet the requirement of the Health Care Guidelines as it excluded components, such as family and social history. The document did not include any assessment by the physicians related to the various medical risk factors. <u>Active Problem List</u> In the sample of records reviewed, 20 of 20 (100%) records contained an active problem list. The lists were not always accurate and updated. Some examples are listed below. • Individual #281 – problem list did not include the diagnosis of thrombocytopenia. • Individual #470 – problem list did not include the diagnosis of GERD. • Individual #570 – received polyethylene glycol and bisacodyl for constipation, but diagnosis does not appear in active problem list. • Individual #417 – was treated for vitamin D deficiency and osteoporosis. The problem list did not include the diagnosis of vitamin D deficiency. <u>Integrated Progress Notes</u> Physicians documented findings in the progress notes. Notes were done in the SOAP format and included the discipline ID, dates, times and signatures. In the sample of records reviewed, 0 of 20 (0%) records contained quarterly summaries by physicians. The exception was the quarterly summary completed by the psychiatrists.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Physician Orders Physician orders included the appropriate information and were dated, timed and signed. **Routine and Preventive Care** In the sample of records reviewed, there was evidence of basic preventive care. Screenings • Audiology evaluations were completed per guidelines in 20 of 20 (100%) of the records reviewed. • Vision assessments were completed per guidelines in 20 of 20 (100%) of records reviewed. • Mammography was completed on three of the five (60%) females who met criteria for an annual mammogram. • Pelvic exams and pap smears were completed in of three of four (75%) females who met criteria for cervical cancer screening. • Fecal occult blood testing (FOBT) for colorectal cancer screening was completed in five of eight (63%) individuals. • Colonoscopy was completed in one of eight (12.5%) individuals. • PSAs were completed in five of five (100%) males who met criteria for testing. Immunizations • Influenza, H1N1, Pneumococcal and Hepatitis B vaccinations – In the sample reviewed, 20 of 20 (100%) records contained documentation of administration of all of these vaccinations. Risk Identification The preventive care flow sheet contained a risk assessment for osteoporosis. There was no other comprehensive assessment of risk by physicians documented in the records. Osteoporosis • The disease prevention flow sheet contained a risk assessment for osteoporosis. • In the 20 records reviewed, there were 14 individuals who met criteria for bone mineral density testing. Dexa scans were completed for 13 of the 14 (93%) individuals. Seven individuals met criteria for osteoporosis, three met criteria for osteopenia, and three were normal. All of the individuals had measurement of vitamin D levels.	

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		Bowel Management • The facility did not have a bowel management program or provide any specific guidelines to physicians on management of chronic constipation. None of the records reviewed for persons with chronic constipation documented any diagnostic work-ups for constipation. • In the sample of records reviewed 14 of 20 (70%) individuals had a diagnosis of chronic constipation. • The following are examples of individuals with chronic constipation who received multiple acute interventions. In each instance, there was no documentation of adjustments to the bowel management of these individuals. o Individual #533 had a diagnosis of constipation and hemorrhoids and was treated with Polyethylene glycol and prn bisacodyl suppositories. No bowel movement x 3 days was documented on the following dates: 4/3/10, 4/26/10, 5/8/10, 6/20/10, and 8/20/10. In spite of multiple episodes of constipation, the records did not reflect any changes in his bowel management program. The records also documented several episodes of nausea and vomiting during this time frame. On 7/7/10, it was suspected that the individual aspirated during one episode of vomiting. The individual was monitored and did not require hospitalization. o Individual #570 did not have constipation listed as an active problem, but received bisacodyl and polyethylene glycol for constipation. The records documented receipt of suppositories on the following days: 8/28/10, 9/4/10, 7/11/10,7/14/10, and 6/18/10. No changes were made in the bowel protocol and no diagnostics had been completed related to chronic constipation. o Individual #239 had a diagnosis of chronic constipation and decubitis ulcer. • On 6/15/10 the individual was seen by the PCP for evaluation of a decubitus ulcer. • On 7/1/10 the individual was noted to have rectal bleeding. • On 7/2/10 the PCP noted rectal bleeding and no anemia. Requested colonoscopy. • On 7/2/10 the PCP noted signs of dehydration and started IV fluids. • On 7/5/10 the PCP commented on the decubitus ulcer. • On 7/23/10 the individual was noted to have bloody stools. • On 8/7/10 the individual had loose stools. • On 8/12/10 the individual was given a rectal suppository due to no BM for three days. • On 8/21/10 the individual received another suppository for no BM in three days.	

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		• On 8/25/10 the individual had diarrhea • On 9/1/10 the individual received a suppository for no BM in three days. • On 9/2/10 the individual was noted to have abdominal distention and was placed on sick call • On 9/14/10 documentation on the individual noted that the right hip wound was abscessed with a large amount of pus and blood draining. This individual's wound was prone to infection due to frequent contact with stool. In each instance that a suppository was given, there was no notification of the physician of a fecal impaction. The bowel management protocol for this individual had no changes made. **Medical Management** The PCPs responded to the needs of the individuals. There were several instances in which follow-up was lacking. This was true for actual clinical assessments as well as for follow-up of diagnostics studies. Specific issues related to follow-up are cited below in the following two sections of examples. <u>Management of acute and chronic problems</u> • Individual #97 had a diagnosis of hypertension. The only medication received for treatment of hypertension was clonidine .3 mg qhs. The records did not provide any explanation for an unusual treatment regimen. • Individual #428 was diagnosed with hypertension at a very young age. Although a 20-pound weight gain may have contributed to the hypertension, other secondary causes of hypertension should have been considered in a young individual. The individual's use of psychotropics should have been evaluated for contribution to the weight gain. • Individual #533 had chronic Hepatitis B. The annual medical assessment stated that the individual was being monitored yearly. The annual assessment did not provide results for the studies, but they were subsequently ordered. There is currently evidence that six-month surveillance in individuals with Hepatitis B improves survival. • Individual #326 had a history of an elevated PSA. The individual was seen by a urologist. In late 2009, the individual refused examination by the urologist. The PSA had been monitored, but remained abnormal. The records did not reflect any strategies on the part of the PST to encourage this individual to continue follow-up. • Individual #161 was reported to have tripped in the gym and hit her head; an abrasion was noted to the back of the head. The MD was never notified and no	

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		neurological checks were performed. <u>Clinical and diagnostic follow-up</u> There was documentation of delays in receipt of results and consults in many records: • Individual #533 was seen by the PCP on 2/5/10 due to minor trauma that resulted in swelling, multiple abrasions, and partial avulsion of a nail. Local wound care was provided. Podiatry was consulted for possible removal of nail. An x-ray was done that day and the PCP documented the preliminary reading as "cannot rule out fracture." The next entry by the PCP was on 2/23/10 when the PCP documented the findings of the final report and consideration of repeating the study. The film was received at the facility on 2/17/10, almost two weeks after it was done. o This individual should have had MD follow-up to determine the status of the partially avulsed nail and to monitor for signs and symptoms of infection. Receipt of a final report two weeks after the event is clearly not acceptable. Preliminary findings should be available within a couple of hours. • Individual #573 had an order for stat FOBT on 1/6/10. The order was carried out on 1/13/10. • Individual #501 had no results for FOBT ordered in February 2010. • Individual #44 had an FOBT ordered on 4/16/09. It was completed on 11/6/09. A colonoscopy was performed on 12/09/09. There was documentation that the report was received on 2/4/10. **Seizure Management** The facility did not have a comprehensive seizure management program, nor did it have adequate mechanisms to track the overall quality of care provided to individuals with seizure disorder. A spreadsheet was provided to the monitoring team that contained all individuals with a diagnosis of seizure disorder and their drug regimens. The medical director reported that there was no database or other mechanism to track key seizure metrics, such as the number of individuals on one, two, or three drugs; the number of individuals on "older" versus "newer" drugs; or the number of persons with intractable seizure disorder. Approximately 118 individual were diagnosed with seizure disorder. Forty-eight percent of the individuals with seizure disorder were receiving the "older" and more toxic drugs, such as dilantin and phenobarbital. There was often no rationale for continued use of these drugs, or a plan to taper the drugs. For example: • Individual #281 was receiving phenobarbital for seizure disorder. There was no rationale for maintaining the individual on the drug nor was there any plan to	

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		taper the individual off of the drug. • Individual #239 was receiving dilantin for control of seizure disorder. The records did not document a rationale for maintaining the drug, or a plan to taper the dilantin. The medical director reported that, until recently, most individual were managed by their primary care physicians. In July 2010, all individuals with a diagnosis of seizure disorder were assessed for the need to have neurological consultation. At the time of the onsite review, several individuals were receiving neurological services at a local facility and more were scheduled to transition into neurological care in the community. Some of the individuals with pending appointments had intractable seizure disorder. For example, Individual #570 had frequent seizures and received dilantin and depakote. He had not been evaluated by a neurologist. In the record sample reviewed, the neurologist had seen seven of 10 (70%) individuals. Initial notes contained detailed historical information, but follow-up notes were brief. Integration of services is critical in the management of seizure disorder. Many individuals with a diagnosis of seizure disorder also had a psychiatric diagnosis. AEDs were often utilized to control seizure disorder and target mood symptoms. The content of the notes reviewed in the chart was not adequate for use in the team process. Individual #104 was seen in neurology clinic in March 2010. The records documented "Patient returned from neurology clinic visit, no note written. Copy of previous EEG results returned. Has f/u appt. in 4 months. Will await typed consult note." The individual was seen in neurology clinic in July 2010. The individual had a history of epilepsy with no seizures for more than two years. The EEG done in March 2010 was normal. The neurologist recommended tapering off Tegretol in four weeks. There was no consideration given to how discontinuing the drug would affect the individual's bipolar disorder. The facility will need to explore options for improving neurological services. It may be possible to have a neurologist conduct the clinic onsite, which opens up the possibility of having neurology-psychiatry consultations as well. Consideration should also be given to drafting a neurology consultation template that shares information with the consultant, but also requests that certain areas of concern be addressed by the neurologist and information provided to the team.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and	The facility had not established a general medical review system. One type of medical review in place was the mortality review and these reviews were completed for all deaths in the year 2010.	Noncompliance

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	maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	The system involved three action steps per policy: 1. Within five working days of notification of death, the physician completes a death summary for the record. 2. Within 14 working days of notification of death (45 with autopsy) the clinical death review committee meets. 3. Within 21 calendar days of completion of review by the clinical death committee (52 with autopsy) the clinical death review committee will forward a report to the administrative death review committee. The goal of the mortality review, as stated in DADS policy, was to provide a comprehensive review of clinical care and operational procedures that may have affected the overall care of the individual. Recommendations for correction actions were to be made when appropriate. Each review committee required the participation of an external representative. Eight deaths were reviewed. During the onsite review, the monitoring team was allowed to review the following documents on each death: • Physician Death Summary • Death Review Investigation, Nursing Services • Clinical Death Review Committee Recommendations • Administrative Death Review Committee Recommendations • Hospital summaries when included in review • Autopsy reports when included in review There were several concerns related to both the process and findings of the mortality reviews: 1. The reviews did not include an objective outside medical reviewer. 2. The current state policy emphasized a review of the 72 hours prior to the death of the individual. While the care provided during the last few days of an individual's life is important, a review that focuses on the last few days, or even weeks, of life does not always provide adequate information to determine if appropriate care was provided. 3. Issues identified at least once by the facility's own reviews included: • Individuals with multiple hospital admissions who lacked development of plans by the PST to address high risk issues • Lack of substantive content in the PSPs • Poor attendance by medical staff at addendum meetings of high risk individuals • Failure to carry out physician orders for diagnostics • Abnormal vital signs not reported to an RN or MD	

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		• A lack of attention to nutritional needs • Untimely receipt of diagnostics completed at outside facilities • Failure to note physician orders in a timely manner • Blanks noted on MARs that were not reported as medication errors of omission 4. The Administrative Death Review Committee cited its own lack of follow-up on recommendations issued by the committee. A plan of correction was implemented to address this problem. 5. There were two causes of death for the eight individuals reviewed: pneumonia and malignancy. Four individuals succumbed to malignancies. Two of the individuals had metastatic disease at the time of diagnosis, one had a stage four malignancy, and one had advanced disease not established by biopsy. The case that lacked biopsy results displayed all of the pathognomonic features of the malignancy. Pneumonia is the leading cause of death in persons with developmental disabilities. The death trends for the facility indicated that greater attention should be given to management of persons at risk for pneumonia and those individuals who have experienced pneumonia. All aspects of care must be evaluated for adequacy. Nutritional management, positioning, respiratory toiletry, oral hygiene and infection control must all be addressed in a timely manner to prevent a reoccurrence of pneumonia. The facility should analyze pneumonia and aspiration data in an effort to discover trends or patterns. PSTs should ensure that persons at risk or with a history of pneumonia have adequate plans. In those cases where recurrent episodes have occurred, the PSTs must be vigilant in exploring options for treatment that might result in improvement. Attention to this matter should be considered urgent. The facility should consider implementation of a medical risk management process that sets thresholds for intense review of cases. The types of cases reviewed could include individuals with pneumonia, individuals requiring ICU admission and individuals hospitalized more than once within a specified timeframe. A system could be developed, such that an individual with one episode of pneumonia be reviewed by the team and appropriate actions taken. Should a second pneumonia occur, a multidisciplinary "clinical review group" would review the individual with the team. In the case of a third episode of pneumonia, the team would be required to present the case to the "clinical review group" with the addition of a clinician with expertise in the area. Four individuals had death attributed to a malignant process. At the time of diagnosis, every individual had either metastatic or advanced disease, such that none of them was	

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		considered a candidate for treatment. This was another problematic trend indicating a failure to detect malignancies at early stages. The facility should examine data related to detection of malignancy in an effort to determine if there are problems with surveillance, prevention, or other factors that resulted in a delay in diagnosis. The medical director should look closely at the current guidelines for colorectal screening to ensure that individuals are being screened in a timely manner using the most appropriate test based on medical history and risk factors. It was clear that the facility was in need of protocols to guide the provision of medical care. Current medical policy directed the physicians to standards adopted by the state. The medical department needs to develop protocols that align with these standards to ensure that physicians are following appropriate guidelines. For example, disease management protocols for Hepatitis B are needed to assist and augment the physicians as clinical judgment is utilized to make decisions. The criteria for treatment of Hepatitis B and surveillance for hepatocelluar carcinoma would be included in such protocols. The agency should implement a process for mortality review that is external to the facility. The primary care physician's summary was a death summary and not a mortality review. Until external reviews are implemented, the facility should give consideration to adding a review by the medical director in an effort to provide a more through and objective medical review.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility did not have a formal medical quality improvement process in place at the time of the review. In discussing medical quality improvement with the medical director, she indicated that the facility was awaiting guidance from state office on this provision. The medical department had not taken any steps towards development of a quality improvement program.	Noncompliance
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care	This provision item referred to the Health Care Guidelines that provided the framework for the standards of medical care to be provided by the facility. DADS Policy #009: Medical Care was issued in July 2010. While the medical department was in receipt of this policy, there had not been any fine tuning of the policies to meet the needs of the agency.	Noncompliance

#	Provision	Assessment of Status	Compliance
	consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility had only one primary care provider that was an employee. Given the constant rotation of physicians into the facility, it is likely that more specific guidelines are needed to assist the primary care physicians.	

Recommendations:

1. The facility must maintain adequate and stable medical staffing. Efforts to recruit and retain physicians should be increased.

2. Facility-specific policies and procedures must be developed to guide the provision of medical care. A facility with rotating physicians will likely have additional needs.

3. The annual assessments should be revised to align with the requirements of the annual plan of care specified in the Health Care Guidelines. Problem lists should be updated with changes as specified in the Health Care Guidelines.

4. Quarterly summaries of each individual's status should be done. These summaries should be standardized and provide a concise summary of the events.

5. A bowel management program is needed. This should focus on important aspects of bowel management, including fluid administration and positioning. Individuals with bowel management problems should undergo appropriate diagnostic testing when necessary.

6. Preventive care flow sheets should be revised to be consistent with the Health Care Guidelines. It would be helpful if the preventive care flow sheets had the criteria for testing such as the age a particular screening should start.

7. Disease management flow sheets should be implemented and available in the records. The focus should be on common conditions as well as conditions commonly seen in persons with developmental disabilities, such as diabetes mellitus, osteoporosis, and hepatitis. These flow sheets must be linked to procedural guidelines on management of these conditions.

8. Guidelines need to be implemented and enforced on the follow-up of persons with acute medical problems and those returning from the hospital. Individuals with acute medical problems, or those returning from the hospital, should receive daily medical evaluation until stable or until the problem is resolved.

9. The facility must ensure that physician orders are noted and acted upon in a timely matter. This includes orders related to treatments and

requests for diagnostics.

10. A system must be developed to ensure that once studies are completed, the results are received and routed to the physicians in a prompt manner. There must be a system to know what studies are outstanding and a mechanism provided for retrieving the information.

11. The current system of having x-rays read is not adequate. The physicians should have access to preliminary reports within a few hours of the study being completed.

12. A comprehensive seizure management policy should be developed. This policy should include the requirements for medical management, documentation in the clinic notes, training, and response to seizures and status epilepticus. Consideration should be given to the development of drug protocols that specify the labs and other diagnostics that must be monitored as well as the frequency of the monitoring. The facility should track essential data related to seizure management, such as polypharmacy and individuals with intractable seizures. These data should be included as part of the medical quality review system, as well as the facility's quality program.

13. A medical quality improvement program is needed. Measures of medical quality must be determined and should include process and outcome measures that are appropriate for the individuals being supported. Once determined, data should be collected and analyzed, and corrective actions taken when necessary. This process should integrate into the facility's quality improvement program.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Active Record Order and Guidelines o Map of facility o An organizational chart, including titles and names of staff currently holding management positions. o New staff orientation agenda o For the Nursing Department, the number of budgeted positions, staff, unfilled positions, current FTEs, and staff to individual ratio o MSSLC Home Descriptors o MSSLC Nursing Policies & Procedures o MSSLC POI and SPOI o Seizure management policy and form (new) o Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due) dates o Nursing staffing reports for the last six months o The last six months, minutes from the following meetings: Infection Control, Environmental/Safety Committee, Specialty Nurses Meeting, Nurse Manager Meeting, Pharmacy and Therapeutics, Medication Error Committee Meeting, o The last six months infection control reports, quality assurance/enhancement reports o List of staff members and their certification in first aid, CPR, BLS, ACLS o Training curriculum for emergency procedures o The last six months, all code blue/emergency drill reports, including recommendations and/or corrective action plans o Infection control monitoring tools o Policies/procedures addressing infection control o List of individuals at risk of aspiration, cardiac, challenging behavior, choking, constipation, dehydration, diabetes, GI concerns, hypothermia, injury, medical concerns, osteoporosis, polypharmacy, respiratory, seizures, skin integrity, urinary tract infections, and weight o List of individuals and weights with BMI > 30 o List of individuals with weights with BMI < 20 o Resident list for HST and Skin Integrity meetings o List of individuals on modified diets/thickened liquids o Documentation of annual consideration of resuming oral intake for individuals receiving enteral nutrition o Medication Error Reporting form o Medication Error Reports for August 2010 o List of nurses with three or more call-ins per month for the past six months o Records of:

	• Individual #12, Individual #3, Individual #390, Individual #221, Individual #6, Individual #77, Individual #28, Individual #517, Individual #538, Individual #92, Individual #599, Individual #574, Individual #75, Individual #477, Individual #270, Individual #453, Individual #271, Individual #399, Individual #389, Individual #134, Individual #331, Individual #570, Individual #222, Individual #268, Individual #515, Individual #89, Individual #306, Individual #212, Individual #155, Individual #345 <u>Interviews and Meetings Held</u>: o Skin Integrity Meeting (9/13/10) o Specialty Nurses Meeting (9/14/10) o Chief Nurse Executive, Norris Buchmeyer o Nursing Operations Officer, Alice Robbins o Quality Assurance Nurse, Karen Wilson o Hospital Liaison, Rosemary Roberts o Nurse Educator, Paulette Calwell o Nurse Recruiter, Gabby Brewer o Infection Control Nurse, Mary Jane Cotton o Wound Care Nurse, Dawn Price o LVN, M5, Beverly Lee o Charge Nurse, Martin, Jameya Glick <u>Observations Conducted</u>: o Medication Administration (Central 7, Central 8, Martin 5, and Whiterock 2) o Medication Counting Procedure (Martin 5) o Enteral Feeding (Martin 5) o Emergency Equipment (Martin 1-6, Central 7, Whiterock 2)
	Facility Self-Assessment: The facility's self-assessment, its POI, for section M indicated that several action steps pertaining to sub-sections M4 and M5 were in substantial compliance with provisions of the Settlement Agreement. The facility identified three areas of substantial compliance. The first area was M4: 8,9, and 10, which referenced the activities of the Hospital Liaison nurse; the second area was M5: A and B, which referenced the activities and outcomes of the Infection Control Department; and the third area was M5: E.2.i, which referenced the activities and outcomes of the care planning process related to weight issues. The comments for the majority of the items/action steps in the facility's POI indicated that training, monitoring, identifying areas for improvement, and revising policies/procedures was underway. In addition, the facility's POI did not indicate sample size or method of review. During the monitoring team's interviews, some members of the Executive nursing team reported that sample sizes were very small and most likely not representative of the facility at large. The monitoring team also learned that the facility scored "N/A" responses on the monitoring checklists as though they were equivalent to a "Yes" or a finding

	of compliance. These two issues raised concern about the validity and reliability of the facility's findings. It is hoped that the facility will re-examine its sampling and scoring methodologies to ensure that valid and reliable results are obtained. Thus, the monitoring team's review of this provision, as detailed in this section of the report, was congruent with the self-assessment's findings of noncompliance in the major sections, M1-M6, however, substantial compliance in several actions steps related to some components of integration of clinical services, management of weight issues/concerns, and infection control surveillance and monitoring were noted.
	Summary of Monitor's Assessment: At MSSLC, the nursing staff members were an experienced and talented group of nurses. The Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison, Nurse Recruiter, Infection Control Nurse, Quality Assurance Nurse, Campus Nurse Supervisors, Nurse Case Managers, and Nurse Managers all displayed tremendous pride and ownership over what they did, and they did not shirk their responsibilities to ensure the implementation of nursing practices and standards to promote quality care. The facility should be commended for its recent reorganization of all individuals' records and significant improvements in record-keeping practices. Records were organized, and nurses' notes were usually in the SOAP (Subjective and Objective (data), Analysis, and Plan) format. It was an infrequent occurrence to find a record note that was illegible, improperly signed and dated, and/or not designated as a late and/or erroneous entry, when or if needed. There was evidence across the 30 individuals reviewed that the individuals' RN or campus RN was usually notified in a timely manner of significant changes in their health status and needs and/or when it became apparent to the LVN that the individual may have needed to be seen in "sick-call" by his or her physician. Properly completed, the standardized nursing assessment forms in use at MSSLC referenced the collection, recording, and analysis of a comprehensive set of health information that led to the identification of all actual and potential health problems, and to the formulation of nursing diagnoses for the individual. In practice, however, 24 of the 30 records reviewed showed that nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions to achieve desired health outcomes. Thus, the conclusion (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This was a serious problem because the HMPs and the selection of interventions to achieve outcomes were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. All 30 individuals reviewed had some of their health needs and risks referenced in Health Management Plans (HMP) and Nursing Care Plans (NCPs). These plans were developed by their RN case manager in

	response to identified health needs, identified risks, and/or significant changes in health status. The forms, processes, and plans in place at the time of the review, however, had problems and were in need of complete review and revision in order to promote progress toward the achievement of this provision of the Settlement Agreement. MSSLC had a health risk assessment rating tool and held a regular health status team meetings. As noted in the baseline monitoring report, and as had continued, these processes had problems that resulted in what appeared to be incorrect ratings of risk for many individuals in important areas of risk and/or failure to increase level of risk in a timely manner such that the likelihood of harm and negative health outcomes was minimized. The administration of medication and the management of the medication administration system at MSSLC had improved since the baseline monitoring tour. As indicated in more detail below, additional work still needed to be in the areas of proper completion of the MARs, management of the medications by the nurses, and in the oversight of medication errors.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Although MSSLC was making progress towards meeting this provision item, a rating of noncompliance was made because of the frequent and regular absence of development of adequate and appropriate plans (HMPs and/or NIPs [nursing intervention plans]) to address/resolve individuals' health problems, needs, and risks through the implementation of planned, individualized interventions. During the conduct of this onsite monitoring review, 15 individuals were visited and 30 individuals' records were reviewed. The facility should be commended for its recent reorganization of all individuals' records and significant improvements in record-keeping practices. Records were organized, and nurses' notes were usually in the SOAP (Subjective and Objective (data), Analysis, and Plan) format. It was an infrequent occurrence to find a record note that was illegible, improperly signed and dated, and/or not designated as a late and/or erroneous entry, when/if needed. There was evidence across the 30 individuals' reviewed that the individuals' RN or campus RN was usually notified in a timely manner of significant changes in their health status and needs and/or when it became apparent to the LVN that the individual may need to be seen in "sick-call" by his or her physician. Once the LVN identified the change/problem and reported it to the RN, the RN usually conducted an assessment of the individual to determine whether or not the individual needed a "sick call," (i.e., needed to be seen by his or her physician). Once the individual was identified for "sick call," a physician usually saw him or her within less than 24 hours.	Noncompliance

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		This process only worked well when the following occurred: 1. Direct care staff member promptly identified and reported a problem to the LVN, 2. LVN promptly responded to the direct care staff member's report and reviewed the individual and situation, 3. LVN reported his or her findings to the RN in a timely manner, 4. RN promptly responded to the LVN's report and conducted a complete face-to-face assessment of the individual, 5. RN's assessment clarified the problem and resulted in a nursing diagnosis, and 6. RN developed an appropriate plan (e.g., continue monitoring, put on "sick call," transfer to emergency medical care facility) that was based upon a complete and comprehensive assessment. For example, on many occasions, Individual #6's direct care staff members promptly identified and reported their observations of alteration in skin integrity to her LVN. The LVN typically responded to the direct care staff members report in a timely manner, evaluated Individual #6's wounds, documented his or her findings, and reported his or her observations to the RN. Also, as was the case on many occasions, Individual #6's RN immediately responded to the LVN's report, conducted and documented a complete assessment, formulated a nursing diagnosis, planned interventions to address Individual #6's problem, and ensured that the interventions were implemented to achieve the desired health outcome – wound healing without complication and reduction in the risk of future alterations in skin integrity As noted above, there were occasions when this process effectively resulted in proper care and treatment, however, improvements were needed in order for it to become a regularly occurring, reliable method of ensuring that individuals received timely and appropriate care and treatment in accordance with their needs and in response to significant changes in their condition. A review of documentation of Integrated Progress Notes showed that the facility failed to ensure that nurses were consistently documenting interventions to address individuals' health care problems and changes in health status, and appropriately recording follow-up to problems once identified. Examples from this sample indicated the seriousness of this problem at MSSLC: ▪ Individual #268 had a history of respiratory problems and had recently recovered from her February 2010 bout of pneumonia and hospitalization. On 9/3/10, Individual #268's LVN noted that she heard "crackles in [her] upper lung fields," and observed her coughing and crying as if in pain. Individual #268's RN conducted an assessment of her several hours later and noted that her lungs were clear, with no crackles, however, 12 hours later, Individual #268's LVN again noted that she observed her coughing and heard crackles in	

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		her upper lung fields. Again the next day, Individual #268's LVN noted that she was crying and coughing, and heard crackles in her upper lung fields. Notwithstanding these observations and findings, there was no evidence of additional follow-up to Individual #268's crying, coughing, and crackling lung sounds and no clarification of the LVN's findings and follow-up assessment by the RN. ▪ On 7/5/10, Individual #574's RN was called to the unit to assess Individual #574, who fell off a chair and landed on her back. The RN conducted an assessment that failed to include an assessment of Individual #574's range of motion or alteration in mobility of joints/extremities, and so forth. Nonetheless, the RN's assessment concluded with a finding of, "Minor scrape noted on [her] right back," "No open areas," "Some redness, but no bruising or swelling at this time." Individual #574's RN's plan was for her LVN to "Follow-up," and "assess for bruising and/or further injury." There was no evidence of follow-up or further assessment of Individual #574 for bruising/further injury. ▪ Individual #517 was a 31-year-old man with uncontrolled diabetes. According to his record notes, his diabetes had been "extremely difficult to control since age seven." During the two months preceding the review, Individual #517's nurses noted fasting blood sugar levels ranging from the 300s to 473. There was no evidence that his nurses notified his physician of these high blood sugar levels. It was not until Individual #517's blood sugar levels rose as high as 485-538 that his nurses notified his physician. Of note, throughout Individual #517's nurses' notes, including the occasions when his blood sugar levels were in the 300s-500s and when he complained of headache, dizziness, and abdominal pain, his nurses peculiarly noted, "No s/s [signs/symptoms] of hyperglycemia noted." ▪ There was a five-day delay in nursing follow-up to Individual #12's extensive thigh bruise, which measured 13.5 cm long and 6 cm wide, and/or the scratches to his chest. ▪ In March 2010, Individual #12's speech therapist recommended honey-thickened liquids to address his risk of choking and aspiration. As of the time of this onsite review, there was no evidence of follow-up to this recommendation and no evidence that Individual #12's risk of choking and aspiration on regular liquids had been addressed. The monitoring team immediately reported this finding to the QA nurse, who was present during this review. ▪ Despite Individual #12's NIP to address his alteration in nutrition related to weight loss, there was no follow-up to his 6/10/10 meal refusal until 6/14/10 when he again refused to eat. There was no evidence of nursing interventions to address Individual #12's meal refusals except for offering him Glucerna. Individual #12 was seen in sick call on 6/16/10 due to presence of a red rash under his right arm and right side of his chest, etiology unknown. ▪ Over the past several months, Individual #3 has suffered recurrent (i.e., at least	

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		weekly) episodes of diarrhea. During these episodes, his nurses administered loperamide and continued to "monitor [his] loose stool," but there was no evidence of complete assessments of his health status by his nurses and no evidence of a complete assessment of his abnormal stools that may assist his physician in diagnosis and treatment of his problem, such as frequency and size of stools, whether or not episodes of diarrhea interrupted sleep (presence/absence of nocturnal diarrhea), presence of blood and/or mucous, formed versus liquid, presence of associated symptoms (i.e., abdominal pain, nausea, vomiting, urgency, gas). Thus, over these months, Individual #3 has suffered skin irritation, breakdown, and infection, and increased anxiety, agitation, and aggressive behavior toward others. ▪ Individual #28 was a 78-year-old woman diagnosed with chronic constipation, and she had a recent history of lower gastro-intestinal bleeding vomiting, and dehydration. In addition, she was considered by her PST to be at "medium" risk of episodes of acute constipation. On 7/3/10, Individual #28's nurse noted that she had not moved her bowels in three days. At this time, Individual #28's nurse administered a dulcolax suppository and noted, "Pending results." There was no follow-up to this problem by Individual #28's nurses. ▪ On 6/4/10, Individual #538 was found with extensive bruising covering his chest, abdomen, left upper arm and forearm. Individual #538's direct care staff member reported that he had vomited during the night before (he was found with the aforementioned bruises), but there were no notes/reports by his nurse of his vomiting during the night, thus, no information to help inform his clinical professionals as to the health issues that may have accompanied or were associated with his injuries. Individual #538 was transferred to the emergency room for evaluation and treatment of his bruises. ▪ Individual #270 had a history of multiple injuries of his lower extremities with multiple surgical procedures. On or about 6/3/10, Individual #270 fell and sustained a serious injury, that is, a tri-malleolar fracture of his ankle as well as spiral fracture of his distal fibula. During Individual #270's recovery period, on an almost daily basis, he complained of headaches. On at least one of these occasions, he was observed hitting himself on the right and left sides of his head. Notwithstanding these significant changes in Individual #270's health status and risks, there were several occasions when there was no evidence that his nurse(s) assessed him for two to four days at a time (e.g., 7/14-7/18/10, 7/18-7/20/10 7/24-7/26/10). ▪ On 8/9/10, during Individual #270's recovery from a tri-malleolar fracture of his ankle and spiral fracture of his distal fibula, his direct care staff member reported that he fell twice. During at least one of these falls, Individual #270 stated that he hit his head. There was no evidence of a complete assessment of Individual #270, including, but not limited to neurological checks. In addition, it	

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		was not until over 12 hours after his fall that his nurse documented that he or she checked his pupil's reaction to light/accommodation. ▪ On 7/12/10, Individual #212's RN was called at mid-night to assess him for his complaints of a sore throat. The RN conducted an assessment, administered Tylenol 650 mg for pain, and recommended that Individual #212 and his staff report any problems or worsening in his symptoms and condition. Although there was a one-hour follow-up note pertaining to the effect/outcome of the administration of medication (i.e., Tylenol), there was no follow-up assessment of Individual #212 or his throat to ensure no worsening of his symptoms or condition. ▪ On 8/6/10, Individual #212 tripped over a walker and fell onto his left side. At the time of his fall, his nurse noted that there was "faint redness to the left side of his abdomen," but he was able to ambulate with his "usual gait." Although Individual #212 was "placed on follow-up for possible injury that may present in the next few hours," there was no evidence of follow-up and no assessment of the nature and extent of his injury. ▪ On 8/25/10, Individual #212 was examined by his physician in response to his complaints of pain in his left ear. Individual #212's physician diagnosed him with otitis media and prescribed antibiotic therapy. There was no follow-up assessment of Individual #212's complaints of ear pain, his tolerance of antibiotic therapy, vital signs, etc. until 10 days later when he completed his antibiotic therapy, but continued to complain of pain in his left ear. On the day of the review, Individual #212 was again referred to sick call and examined by his physician who noted, "Copious, yellow drainage inside [his] ear." ▪ On 7/2/10, Individual #306 stated that on 7/1/10, his roommate had sex with him and his "bottom hurt." Although Individual #306's bedroom assignment was changed and his level of supervision was increased, there was no evidence of a complete physical examination and assessment that included an assessment of his complaint(s) of pain and possible physical/sexual assault. Although an assessment/examination of this nature may be beyond the scope of Individual #92's nurses' duty, there was no evidence that he was referred to the appropriate clinical professionals to ensure that an appropriate assessment of his complaint(s) of pain and possible physical/sexual assault was performed. ▪ Also on 7/2/10, Individual #306's direct care staff member reported that Individual #306 was hit in the right eye and grabbed around the neck by a peer. His nurse obtained an incomplete set of vital signs and conducted an incomplete and inadequate assessment of him. Individual #306's nurse noted that his eyes were "clear" and his skin was "intact" with no redness, bruising, swelling, or pain, and concluded with a plan to "monitor for possible injury." There was no evidence of a complete assessment of Individual #306's eye, including, but not limited to, assessment of changes in vision, and no follow-up monitoring or	

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		assessment for possible injury. ▪ Individual #221 was a 58-year-old male diagnosed with chronic kidney disease stage III, hyperlipidemia, anemia, and nicotine dependence. Individual #221 had not had a screening for colon cancer, and he has purportedly "refused all attempts for FOBT (fecal occult blood test)," during February 2010 to April 2010. Despite Individual #221's nurses' reports that he "refused" care, there was no evidence of follow-up by his nurses to encourage and promote his compliance with participation in important preventive health screenings. In addition, although two nurses noted that Individual #221 was "getting his meds mixed up," there was no evidence of follow-up to ensure that he received his medications in a safe and appropriate manner.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	Current annual and/or quarterly nursing assessments were not present in 10 of the 30 records reviewed. The monitoring team reported this finding to the facility, who responded with the submission of several additional documents to address this issue. Thus, as of this report, there were current annual and/or quarterly nursing assessments for 22 of the 30 records reviewed. One of the 22 (Individual #212), however, had a six-month time period, 9/09-3/10, where no nursing assessments were completed. Of the 30 records reviewed, most of the nursing assessments were not complete or comprehensive and, therefore, a rating of noncompliance has been given to this provision item. The first step of the nursing process that one would expect to find in a facility, such as MSSLC, is the nursing assessment. The nursing assessment is an ongoing and continuous process of collecting, evaluating, and communicating data and information regarding each and every individual's needs, regardless of the reason for the nursing encounter. Generally accepted professional standards of care indicate that nursing assessments must be complete, accurate, documented, and accessible to all members of the healthcare team. Moreover, it is from the nurses' assessment that actual problems, high-risk potential problems, and nursing diagnoses are identified, and from which plans are developed to address and/or resolve problems. At MSSLC, the nursing assessment was of even greater since it was the only process whereby individuals' nurses' compiled, analyzed, and recorded their evaluations of individuals' health status and their responses to treatment interventions from "head to toe." At MSSLC, IPNs were episode-driven (i.e., they were notes written in response to narrow, specific, and significant changes). Although the Health Care Guidelines did not prescribe an exact "right" frequency or format for reporting and recording an individual's progress, they did indicate that a review of the record should reveal each individual's progress in maintaining or improving functional abilities, which includes both health and psychosocial status. They also indicated that the clinical record should document change	Noncompliance

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		toward achieving care plan goals and provide adequate progress information necessary for the staff members to work with the individual. This certainly would imply that regular progress information was necessary in order to assess/evaluate the adequacy and appropriateness of the care plan as it was reviewed quarterly vis a vis the quarterly nursing assessment. Properly completed, the standardized nursing assessment forms in use at MSSLC referenced the collection, recording, and analysis of a comprehensive set of health information that led to the identification of all actual and potential health problems, and to the formulation of nursing diagnoses for the individual. For example, Individual #92 was a 36-year-old man who was diagnosed with HIV, mild dementia secondary to HIV, asthma, and chronic bronchitis, for which he was prescribed daily doses of guaifenesin, an expectorant drug usually taken by mouth to assist the expectoration of phlegm from the airways in acute respiratory tract infections. Individual #92's nursing assessments provided a comprehensive review of his health status indicators, evaluated the effectiveness of his treatment with anti-viral medication, and generated nursing diagnoses that provided an adequate basis for selection of interventions to achieve his desired health outcomes. Notwithstanding the presence and use of these forms, in 24 of the 30 records reviewed, nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions to achieve desired health outcomes. Thus, the conclusion (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This was a serious problem because the HMPs and the selection of interventions to achieve outcomes were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. Examples are given below: <u>Regarding specific individuals</u> ▪ Individual #75 was diagnosed with hyperlipidemia, and he was prescribed cholesterol-lowering medication, which may result in elevated liver enzymes. Although a routine check of his liver function revealed slightly elevated, yet abnormal, results, his annual nursing assessment erroneously noted, "No abnormal [LFT] results. Individual #75's nursing assessments also failed to reference his onychomycosis and response to treatment of his skin rash and episodes of nausea, vomiting, and diarrhea. ▪ Over the past several months, Individual #270 had been recovering from a trimalleolar fracture of his ankle and spiral fracture of his distal fibular with	

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		open reduction and internal fixation. Since Individual #270's most current nursing assessment (3/28-6/28/10), he had suffered falls, bruises to his torso and upper and lower extremities, almost daily complaints of headache, and break-through seizure. Notwithstanding these significant changes in Individual #270's health status and risks, as of this onsite review, there were no complete nursing assessments conducted since June 2010. According to the Health Care Guidelines and standards of practice, nursing assessments must be conducted annually, quarterly, and upon significant change(s) in an individual's condition. ▪ Although Individual #515's nursing assessments affirmed that she had "vision impairment," the assessments did not provide sufficient information or elaboration to reveal the extent or implications of her impairment (i.e., she was legally blind). In addition, Individual #515's nursing assessments concluded with an incomplete list of nursing diagnoses. For example, during Individual #515's assessment periods, she experienced rash, fungal infection, abscess, and conjunctivitis, however, alteration in her skin integrity was not included on her list of nursing diagnoses. Also, although during Individual #515's assessment periods, she had episodes of high blood pressure and hypertension was added to her medical problem list, her responses to these problem and the current/potential risks related to heart disease were not included on her list of nursing diagnoses. ▪ Individual #212's nursing assessments failed to reference his problems and risks related to constipation. ▪ Individual #222 was diagnosed with osteoporosis. She was also non-ambulatory, had limited range of motion, was recovering from a right leg fracture (4/10), and received physical therapy. Notwithstanding her significant musculoskeletal needs and risks, her nursing assessments failed to adequately assess this area and address the impact of the actual and potential health problems on Individual #222's quality of life. Rather, the only brief references to these problems was the phrase, "4/12/10 intramedullary rod and nail fixation for right distal femur fracture," entered under the heading, "Surgical History" and "4/12/10 individual was transported to Scott and White for right distal femur fracture," entered under the heading, "Nursing Summary." ▪ According to Individual #6's Annual Medical Evaluation (11/16/09), she was blind in her right eye and deaf in her left ear, however, neither of her sensory impairments was referenced in her nursing assessments. ▪ Over the past several months, Individual #517 had complained of weight loss. Indeed, he had suffered an unplanned loss of more than 20 pounds over the past year. In the IPNs, Individual #517's nurses noted his frequent meal refusals, proclivity for non-nutritious food/drink, and noncompliance with his dietician's recommendations and prescribed diet. Nonetheless, his nursing assessments erroneously portrayed him as having "excellent" nutrition, "eating a balanced	

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		diet," and having no problems/risks related to proper nutrition. ▪ Individual #221 was a 58-year-old man diagnosed with chronic kidney disease (CKD) stage III, hypertension, hyperlipidemia, anemia, periodontal disease, and skin/nail problems. In addition, Individual #221 was a smoker. Although Individual #221 was at high risk of development/progression of complications of CKD that start during stage III of the disease process (e.g., high blood pressure, anemia, kidney pain, early bond disease, sleep disturbance, fatigue, edema of legs, hands, face, shortness of breath, changes in urination), his nursing assessments failed to reference the stage of his CKD and its associated risks and failed to generate complete and accurate nursing diagnoses to adequately identify interventions to reduce the likelihood that he will experience these complications (or slow their progression). ▪ Individual #390 was a 65-year-old man with many significant health problems and risks. Over the past year, he suffered multiple episodes of Dilantin toxicity, pneumonia, and urinary tract infection. In addition, he had chronic deep vein thromboses, severe dysphagia, severe onychomycosis of all toenails, decreased range of motion and contractures of extremities, weight loss, and impaired skin integrity. Individual #390's nursing assessments were incomplete and failed to provide adequate assessment of his skin, nails, ears/eyes/nose/throat, head and neck, cardiac, respiratory, gastro-intestinal, musculoskeletal, neurological, and genitourinary systems. In addition, although Individual #390's nursing assessments noted that he had "hypertrophic toenails" and "podiatry clinic pending," there was no follow-up to these assessments. Thus, as of the monitoring team's review, Individual #390 had not received podiatry care in accordance with his needs. ▪ Individual #77's nursing assessments did not provide a complete list or review of the outcomes of her consultations, nutrition management, fracture history, or health status. For example, her nursing assessments failed to reference her risk of hyponatremia (related to Depakote-induced SIADH-syndrome of inappropriate antidiuretic hormone secretion), herpes zoster infection, and vision impairment (i.e., cataracts). ▪ Individual #389 was 75-year-old woman diagnosed with non-insulin dependent diabetes mellitus, hyperlipidemia, hypertension, osteoporosis, Parkinsonism, constipation, cataracts, and periodontal disease. In addition, she was non-verbal and non-ambulatory. Individual #389's nursing assessments failed to provide an adequate summary of the effectiveness of her medications and treatments, which was especially relevant to proper management of her diabetes and high cholesterol. Further, although Individual #389's occupational therapist noted that she was "unable to sit upright," and her physical therapist noted that she was "de-conditioned," the impact and relevance of these findings on her actual and potential health problems was not addressed by her nurses vis a vis the	

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		nursing assessments. ▪ Individual #134 was a 79-year-old woman diagnosed with seizure disorder, hypertension, tardive dyskinesia, osteoporosis, cataracts/legally blind, varicose veins, status-post skin cancer, and onychomycosis. During Individual #134's annual medical evaluation, her physician noted that she had moderate contractures, and marked limitation of movement and very diminished strength of her upper and lower extremities. Individual #134's nursing assessments failed to reference her significant musculoskeletal problems, needs, and risks. Rather, Individual #134's nursing assessments indicated "No abnormal findings" of her upper and lower extremities. ▪ Since Individual #3's most current quarterly nursing assessment (2/9/10-5/9/10), he suffered almost weekly episodes of diarrhea, skin breakdown, increased anxiety and agitated/aggressive behavior, falls, and increased dosages, including PRN administration, of psychotropic mediation. Despite these significant changes in his health and psychosocial status and functioning, there were no complete nursing assessments conducted after the above-reference quarterly nursing assessment. According to the Health Care Guidelines and standards of practice, nursing assessments must be conducted annually, quarterly, and upon significant change(s) in an individual's condition. ▪ Since Individual #331's most current quarterly nursing assessment (1/11/10-4/11/10), he had suffered recurrent episodes of pedal edema (such that "bed rest" was prescribed), decubitus ulcers, diarrhea, anorexia, dehydration, weight loss, hypoalbuminuria, and fungal, yeast, and bacterial skin infections (staphylococcus). Despite these significant changes in Individual #331's health status and functioning, there were no complete nursing assessments conducted since April 2010. As noted above, according to the Health Care Guidelines and standards of practice, nursing assessments are conducted annually, quarterly, and upon significant change(s) in an individual's condition. ▪ Individual #345's nursing assessments failed to reference his health risks and response to potential/actual problems associated with his hypothyroidism, benign prostatic hypertrophy, degenerative joint disease, onychomycosis, and early cataracts. ▪ During Individual #155's Annual Medical Evaluation, his physician noted that, in addition to Individual #155's other health problems, he had periodontal disease and his muscles were "in total spasticity," his "legs [were] very tight, tense, and rigid," and he "could barely stand up with a gait belt." In addition, Individual #155's history of falls with injuries was noted. His nursing assessments failed to reference his oral hygiene problems and did not adequately assess his musculoskeletal abnormalities, which clearly went beyond "spastic at times" and his psycho-social needs, which were not limited to reducing his risks associated with "self-injurious behavior."	

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		▪ Individual #12's nursing assessments noted that he had fungus present on his toenails, but there was no follow-up by his nurses to his podiatrist's recommendation for him to receive follow-up podiatry care/treatment. In addition, Individual #12's nursing assessments erroneously indicated that he had "no abnormal findings" of his extremities even though his extremities, including his hips, elbows, knees, and hand, were contracted. ▪ Individual #599 was diagnosed with diabetes, hyperlipidemia, and constipation. Over the past year, he had frequently refused to keep his dental appointments and was noted to have poor oral hygiene and heavy bleeding during oral care. Despite these health problems and risks, Individual #599's nursing assessments failed to reference his periodontal disease. ▪ Individual #89 was a 34-year-old man who was diagnosed with diabetes, asthma, chronic bronchitis, Vitamin D deficiency, hyperlipidemia, onychomycosis, tinea pedis, suspect early retinopathy, and insomnia. Over the past several months, Individual #89's record notes indicated that he complained of pain and burning of his feet. Despite his complaints and his "severely uncontrolled" diabetic status, his nursing assessments failed to reference his foot problems/risks. ▪ Individual #28's nursing assessments were missing data related to the assessment of her functional status. In addition, the assessments failed to reference the impact of episodes of recurrent urinary tract infections, gastrointestinal problems (e.g., vomiting, bleeding, and dehydration), pressure sores on both buttocks, and anemia on her health status and risks. ▪ Individual #574's nursing assessments were missing data related to the assessment of her functional status and sections VII (Infection and Immunization) through X (Health Management and Acute Care Plans). <u>Regarding numerous individuals</u> ▪ Many of the individuals' skin integrity problems and risks were not adequately assessed by their nurses. Most of these individuals' problems with maintaining intact skin was not due to pressure/immobility per se, but due to one or more of the following problems: self-injurious behaviors, self-inflicted open wounds due to scratching dry and itching skin, recurrent skin infections/rashes (including but not limited to fungal and/or yeast infections), non-healing wounds (including, but not limited to, ostomy sites), improperly fitting medical equipment, and so forth. ▪ Many of the individuals' chronic conditions, usually constipation, incontinence, and immobility, sensory deficits, usually vision and hearing impairments, and psycho-social challenges, including, but not limited to aggressive and/or self-injurious behavior, were either not referenced in their nursing assessments or they were significantly under scored.	

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		▪ Several individuals who received multiple suppositories and/or enemas a week in order to have a bowel movement had nursing assessments that erroneously indicated that they had "no problems" with constipation. ▪ The health status of individuals who suffered complications of diabetes and/or chronic kidney disease were not adequately referenced, analyzed, or diagnosed vis a vis the nursing assessment process. ▪ Preventive screening information, including vaccination/immunization status, were incomplete across most individuals reviewed.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Health management plans (HMPs) and acute care plans (called Nursing Care Plans - NCPs) existed at MSSLC. The plans needed a great deal of improvement as detailed below in order to meet the requirements of this provision item. Consequently, this provision was rated as being in noncompliance. In a facility such as MSSLC, health management plans and acute care plans are designed to promote health and/or prevent, reduce, or resolve the problems and risks that are identified via the nurses' assessment and nursing and medical diagnoses. In total, the nursing care plans should reference all of the individual's acute health issues, including injuries, actual and potential health risks, restorative and habilitative needs, and chronic/long term health needs. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals, objectives, and outcomes. The individual's status, and the effectiveness of the plans, must be consistently implemented and continuously evaluated and modified as needed. All 30 individuals reviewed had some of their health needs and risks referenced in Health Management Plans (HMP) and Nursing Care Plans (NCP). These plans were developed by their RN case manager in response to identified health needs, identified risks, and/or significant changes in health status. The forms, processes, and plans in place at the time of the review had problems and were in need of complete review and revision in order to promote progress toward the achievement of this provision item of the Settlement Agreement. Part of the problems noted in the HMPs and NCPs were due to the problems noted above in nursing assessments and diagnoses (sections M1 and M2 of this report). Some general comments are presented below. ▪ Across all 30 individuals reviewed, HMPs were in a consistent form/format. The HMPs, which were dated with the "Date Begun," started with a "Goal" and "Service Objectives," followed with "Baseline Measure(s)," and ended with an overall "Health Care/Wellness Plan" and signature by the RN case manager. ▪ Across all 30 individuals reviewed, the HMPs did not consistently address all of	Noncompliance

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		the health care needs of the individuals, and NCPs were not consistently prepared in a timely manner, or at all, in response to individuals' acute and/ or emergent health care problems and risks. ▪ Some of the 30 individuals reviewed had "mini" medical disorder, also known as "stock," care plans added to their HMPs. These "mini-plans" included such plans as the Asthma Plan, Allergic Rhinitis Plan, Dry Skin Plan, Constipation Plan, GERD Plan, Seizure Plan, Anemia Plan, Osteoporosis Plan, Diabetes Plan, Parkinson's Disease Plan, and Hyperlipidemia Plan. Although the medical disorder care plans appeared to be added to the individuals' HMPs to provide additional direction and guidance to caregivers, these plans were not specific enough for caregivers to be able to pick it up and effectively continue the care. The medical disorder care plans had not been adequately customized and/or personalized to address individuals' specific health problems and risks. Rather, they referenced generic interventions mostly related to "monitoring" and "reporting" activities and usually instructed the reader to follow other "plans" (e.g., "See HMP," "Per "Follow BMP," "Maintain per PNMP," "See physician's orders"). ▪ Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and NCPs were not revised, and they did not reflect the most current conditions and intervention strategies. ▪ There was no evidence that, at least quarterly, individuals' nurses conducted a comprehensive review of the individuals' HMPs and current NCPs to ensure that the plans continued to be appropriate and relevant to the individuals' health status. ▪ The objectives and expected outcomes referenced in the HMPs and NCPs were not individualized, and they did not reflect the individuals' participation in their development or the formulation of their desired health outcomes. ▪ The Nursing Assessment portion of the individuals' PSPs was not informative and did not provide even a brief recapitulation of the individuals' health status over the past year. In addition, usually only two to three of the individuals' health objectives or goals were mentioned, and, usually, it was recommended that the reader "see Nursing Assessment" for more information. Examples of problems in the HMPs and NCPs of specific individuals are presented below: • Individual #92 was a 36-year-old man diagnosed with HIV, mild dementia secondary to HIV, asthma, and chronic bronchitis. He also smoked cigarettes. According to Individual #92's' 7/20/09 PSP, his HMP should address his health care needs related to freedom from complications of HIV. His HMP, however, failed to put forward appropriate individualized interventions to address his needs for proper diet and nutrition, adequate hydration, good oral hygiene,	

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		health education and teaching about his disease and prevention of transmission, including substance abuse and safe sex practices. In addition, rather than a goal to remain "free" of complications related to his HIV, his HMP's goal was to experience "less than eight (8) episodes of complications of HIV (emphasis added)." This is not a desired health outcome, and Individual #92's clinical professionals should correct it. • Individual #599 was a 34-year-old man diagnosed with diabetes, depression, hyperlipidemia, constipation, and dry skin. Individual #599 was Vietnamese, and he spoke no English. According to his clinical professionals, he frequently refused meals, medications, and dental and medical treatment. Individual #599's 9/14/09 HMP listed his needs as diabetes control, altered skin integrity, and weight gain, however, his HMP mistakenly included a "mini-plan" to gain, rather than lose, weight, but this was not corrected or revised. His HMP also failed to address his poor oral hygiene, psychosocial needs and risks (especially those related to non-adherence to dental and medical recommendations), alteration in diet and nutrition, and communication barriers. In addition, one of his HMP's goals was, "will experience 12 or less episodes of alteration in skin integrity (emphasis added)." This is not a desired health outcome, and Individual #599's clinical professionals should correct it. Another one of Individual's #599's HMP's goals was to lose one to three pounds a month. Although no progress had been made toward the achievement of this goal, the interventions had not been revised. • Individual #221 was diagnosed with chronic kidney disease stage III, hypertension, hyperlipidemia, anemia, periodontal disease, onychomycosis, and tinea pedis. His HMP's "Renal Disease Plan" recommended "observing" him for shortness of breath, vomiting, abdominal distention, "monitoring" his complaints of dry mouth/excessive thirst, "administering" his medications, and "assuring his labs are done." Notwithstanding these recommendations, Individual #221's HMP failed to provide a clear plan of action to address the complications of CKD that start at stage III (e.g., anemia, early bone disease, sleep disturbance, changes in urination). Peculiarly, Individual #221s 1/4/10 PSP indicated that he had no endocrine, gastrointestinal, or genitourinary problems. • Individual #222 was diagnosed with intractable seizure disorder, osteoporosis, constipation, and myopia. In April 2010, Individual #222 suffered a fractured leg while bathing, and in May 2010 she was hospitalized for treatment of seizures and urinary tract infection. Individual #222 had NCPs developed to address her fractured leg and increased seizure activity. Individual #222's HMP referenced four service objective and four plans, but the plans were not related to the objectives, and the objectives were not related to the plans, that is, there was an objective to experience no complications of osteoporosis, but no plan of	

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		action to achieve that objective. Conversely, there was a Pain Plan, but no objectives/goals/outcomes were identified. • Of note, the bases for Individual #222's HMP's Service Objectives were unclear and raised concern. For example, her service objective related to seizure was that she "will experience 12 seizures or less during the next 12 months," the service objective related to constipation was that she "will experience less than 10 episodes of constipation during the next 12 months," and the service objective related to GERD was that she "will experience less than 3 complications of GERD during the next 12 months." It is strongly recommended that Individual #222's clinical professionals review and revise these objectives, especially since any one of these complications is not a desired health outcome and not without serious consequences and complications, including death. • Individual #12's 4/2/10 HMP failed to reference his health needs and risks related to osteoporosis, hyperlipidemia, alteration in skin integrity, sensory deficits, and increased behavior problems such that his psychiatrist increased his daily dose of Risperdal. • Over the past six months, Individual 6's RN developed many NCPs to address Individual #6's acute care needs. For example, she developed plans to address her episodes of altered skin integrity (e.g., abscess, boil, cellulitis, human bite wounds) and fractured toe. Notwithstanding this positive finding, Individual #6's 12/15/09 HMP failed to address her poor oral hygiene (which was especially relevant since she has started chewing tobacco), osteopenia, constipation, and sensory deficits. Since the implementation of Individual #6's HMP, she had failed to make progress toward her desired weight loss goal and has actually gained weight. Nonetheless, the interventions to promote her weight loss had not been revised. Also, Individual #6's service objective related to her problem of recurrent urinary tract infections was that she "will experience no more than four (4) urinary tract infections." Individual #6 had a urostomy, and regardless of the number of infections she had suffered over the past year, this objective was not a desired outcome. Each episode of infection exposed her to the risk of developing severe complications. This objective should be reviewed and revised by Individual #6's clinical professionals. • Individual #155 was a 35-year-old man diagnosed with seizure disorder, osteopenia, mild myopia, constipation, psoriasis, and periodontal disease. According to Individual #155's physician's 11/9/09 Annual Medical Evaluation, his muscles were in total spasticity, his legs were very tight, tense, and rigid, and he was barely able to stand up with a gait belt. Individual #155's 12/18/09 HMP referenced his problems with seizures, risk of falls, weight gain, and alteration in skin integrity, however, it failed to reference his sensory impairments and impaired physical abilities and self care deficits. In addition, the service	

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		objectives related to Individual #155's risks were in dire need of review and revision by his clinical professionals. For example, Individual #155's HMP incongruously referenced that he "will experience no more than 24 episodes of altered skin integrity," "will experience no more than 4 eye infections," "will experience no more than 4 falls," and that he "will experience 12 seizures or less" this year. Although these objectives may have revealed what Individual #155's PST expected to occur over the next 12 months, putting forward plans/interventions to achieve these "goals" was a disservice to Individual #155, and they were certainly not desired outcomes. • Individual #399 was a 79-year-old woman with many health needs and risks. She was diagnosed with GERD, dysphagia, hypotension, borderline hyperlipidemia osteoporosis, hypothyroidism, fibrocystic breast disease, cataracts, myopia, allergic conjunctivitis, chronic/intermittent leukopenia, tinea pedis, rule-out melanoma, and extensive left lower leg deep vein thrombosis, which requires life-long treatment with anticoagulant due to immobility. Individual #399 was also non-verbal and non-ambulatory and suffered recurrent urinary tract infections. Individual #399's HMP referenced her health needs and risks, but the interventions for outcome achievement required review and revision in order for any nurse to be able to pick up Individual #399's HMP and effectively deliver her health supports and services. For example, Individual #399's HMP interventions related to reducing her risk of aspiration included interventions associated with "enteral feeding" which did not pertain to Individual #399. In addition, the interventions related to reducing Individual #399's risks associated with anticoagulant therapy stated that treatment may be delivered "per nursing" (versus referral to her physician) for "small bruising" and "bleeding that stops fairly quickly." Both of these phrases were too vague and subjective to adequately and effectively ensure her health and safety. • Individual #399's 8/2/10 PSP recommended that her HMP should address her constipation, hypothyroidism, cardiac disease, recurrent urinary tract infections, GERD, osteoporosis, weight gain, and gynecological problems. Notably, her PSP did not reference her problems and risks related to her extensive deep vein thrombosis, anti-coagulant therapy, and immobility. • Individual #538 was a 48-year-old male with a history of myocardial infarction. He was diagnosed with coronary artery disease, hyperlipidemia, GERD, seizure disorder, osteoporosis, periodontal disease, and constipation. Individual #538's 2/17/10 PSP indicated that his "most troubling, challenging behavior is his complaints of chest pain," which he used to gain attention and avoid/escape demands. Individual #538's PST recommended, "all medical protocols should be followed when he reports chest pain." Despite his PST's recommendation, he did not have a specific protocol for his nurses to follow when he complained of chest	

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		pain. Thus, it was not surprising that over the past several months, his complaints of chest pain had escalated. In addition, his treatment of chest pain had advanced from Tylenol to nitroglycerin without evidence of a change in the nature or severity of his pain. A review of Individual #538's IPNs revealed no significant correlation between the nature and severity of his complaints of chest pain and his nurses' administrations of Tylenol versus nitroglycerin. Rather, it appeared as though Individual #538's receipt of Tylenol versus nitroglycerin varied in accordance with the nurse who was on duty at the time of his complaint(s). Use of nitroglycerin is not without risk because it may result in acute hypotension. In addition, nitroglycerin has other effects such as relaxation of the lower esophageal sphincter, which may increase Individual #538's risk of reflux and aspiration. Thus, this issue should be thoroughly reviewed by Individual #538's clinical professionals and a proper protocol should be developed, as recommended by his PST. • Individual #28's HMP failed to address the pressure sores on her buttocks and her onychomycosis. Individual #28 also did not have a NCP developed to address the right hand contusion she suffered on 5/29/10. Her 8/10/10 PSP failed to include any comments from her nurse about her health status, needs, and response to treatment interventions over the past year. Rather, the nursing section of Individual #28's PSP referred the reader to, "See Nursing Assessment." • Individual #3 had suffered recurrent, almost weekly, episodes of diarrhea for several months. His 11/9/09 HMP failed to reference this problem despite the fact that it had significantly affected his quality of life, including but not limited to skin breakdown and infection, increased anxiety and agitation, interrupted sleep, and so forth. Over the past several months, Individual #3's PST has met to discuss his "chronic diarrhea" and "diet," but a review of the sign-in sheets for these meetings revealed that his physician was not present at these meetings to help guide and direct the development of a treatment plan to address this long-standing problem. • Individual #3's 11/4/09 PSP failed to include any comments from his nurse about his health status, needs, and response to treatment interventions over the past year. Rather, the nursing section of Individual #3's referred the reader to, "See Nursing Assessment."	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals	At MSSLC, nursing assessment protocols were in place, however, the presence of protocols was not sufficient to ensure that the health status of the individuals at MSSLC was consistently addressed. As noted above, there were numerous problems as described in Sections M1, M2, and M3. In addition, various members of the nursing management team reported that there had been recent development of a number of processes and plans, many of which were still being reviewed, revised, and finalized.	Noncompliance

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	served.	Thus, the anticipated positive outcomes for individuals due to the implementation of these protocols were not evident in the records reviewed. Therefore, this item was rated as being in noncompliance. At MSSLC, the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison, Nurse Recruiter, Infection Control Nurse, Quality Assurance Nurse, Campus Nurse Supervisors, Nurse Case Managers, and Nurse Managers all had a role and responsibility to ensure the implementation of nursing assessment and reporting to address the health status of the individuals. The members of the nursing management team had many years of experience in nursing and most of them had worked in various roles and served in many capacities at MSSLC. Collectively, their knowledge of previous procedures, their contributions to current improved practices, and their abilities, which will shape the future of quality nursing care at MSSLC, were invaluable. The expectation for adequate numbers of trained, competent, and capable nurses was clearly articulated by the Chief Nurse Executive (CNE). According to the CNE, the facility continued to be "short-staffed" (i.e., the facility was short 25 LVN positions and had five vacant RN II positions). Thus, as noted during the baseline review, use of contract agency nurses continued and will continue for the foreseeable future in order to meet staffing levels/requirements/minimums. To address prior concerns related to the use of contract agency nurses' compliance with the facility's assessment and reporting practices and protocols, the CNE reported that the Nurse Recruiter carefully selected, trained, monitored, and evaluated the contract agency nurses' performance and adherence to standards of practice. If the Nurse Recruiter had any doubt or question in her mind about the character and/or competence of a contract agency nurse, she had the authority to assign the individual to the facility's "DNR" (do not return) list. Since the baseline monitoring review, the CNE reported that the timeliness of nursing assessments had markedly improved. The task at hand, however, was to improve the quality of the nursing assessments. The CNE provided an example of one effort to improve the quality of nursing assessment and reporting – "Peer Review." According to the CNE, on a quarterly basis, the Nurse Educator convened a work group comprised of home nurses that reviewed assessments and care plans and made recommendations to improve their quality. The CNE emphasized that this process was not punitive, rather it was a positive process that had resulted in better performance by the nurses who participated in the process. The CNE also reported that the facility had faced challenges in the area of integration of clinical services. They had, however, improved their performance in this area through the efforts of the Hospital Liaison and through better communication with the facility's Medical Director, who had been more amenable to improving the coordination of	

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		medical and nursing care. Notwithstanding these efforts and improvements, one of the barriers to implementation of the improved nursing assessment and reporting protocols was the lack of authority of the home nurse to direct or manage the delivery of health care services and duties delegated to direct care staff members. The Nursing Operations Officer (NOO) supervised the nurse case managers and nurse managers. The NOO was very knowledgeable of the areas that had shown improvement as well as the areas that had been resistant to change. For example, she reported good attendance at the monthly nurse manager meetings and improved cooperation and participation of staff members from departments, other than nursing, in the development and implementation of nursing care plans. According to the NOO, the two areas that continued to require improvement were (a) excessive "call-ins" by the LVNs, and (b) medication administration practices and medication errors. The Nurse Recruiter echoed the CNE's report of lack of approved LVN positions and vacant RN positions. Despite her efforts to recruit and retain nurses, especially LVNs, she clearly articulated that the facility needed contract agency nurses and did not foresee when they would not be needed. The Nurse Recruiter had a presentation book outlining the efforts underway by her department to recruit and retain qualified nurses. She had an excellent relationship with all of the contract agencies and Navarro College, and she had much success with advertisements on the radio. According to the Nurse Recruiter, there were no annual raises last year and merit raises stopped at some point during the second quarter of 2010. This had not been good for the morale of nurses in general and especially not good for the morale of the nurse case managers. The Nurse Recruiter spent a great deal of time monitoring and evaluating the performance of the contract agency nurses. She believed that the contract agency nurses must demonstrate that they are aware of the facility's assessment and reporting protocols and that their performance must meet standards of practice. If they do not, they will be put on the "DNR" (do not return) list because, first and foremost, "…They are here to accommodate us." The Infection Control Nurse was involved in most aspects of nursing assessment and reporting. Wherever and whenever a need for infection control training, education, monitoring, and/or review was identified, the Infection Control Nurse was present and available to provide expert advice and training. She was well-versed in the standards of infection control. She had developed and maintained electronic records of flu shots, TB	

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		tests, and infections, and was in the process of creating a database of individuals' immunizations. The Infection Control Nurse also received information from the facility's physicians and pharmacy related to antibiotic prescriptions and practices across the facility. The Infection Control nurse recorded all of the information related to identification, tracking and trending, and reporting of infections in a database. She presented these data to the facility's Infection Control Committee during their monthly meetings. As part of her role to monitor the processes of identifying, reporting, evaluating and treating infections, she conducted reviews, vis a vis infection control monitoring tools, of post-pneumonia care and treatment, incontinence care, MRSA, and urinary tract infections. During her conduct of the reviews, it was evident that she spent time teaching direct care staff the meaning of standard precautions, techniques to reduce the risk of transmission of infection, proper sanitizing and disinfecting of bath/shower areas, dining room tables. The Infection Control Nurse made it her business to provide direct care staff members with re-education and training in standard precautions and to follow-up on individuals who were diagnosed with infections. The Infection Control Nurse also provided technical assistance to home and campus nurses who had questions about specific infection control practices and procedures. There was no job too big or too small for the Infection Control Nurse. The Hospital Liaison was directly involved in the daily process of nursing assessment and reports. She was passionate about her job and about ensuring that all individuals who were hospitalized were visited, and that all pertinent information about their hospitalization was collected and reported to their caregivers at MSSLC . She communicated her assessment of individuals' hospital care/treatment and their response to treatment via daily written reports, which were sent to the individuals' nurse case managers, physician, and DCS Supervisor, and were also filed in the individuals' records. The Hospital Liaison's activities and reports were complete, comprehensive, and informative. The Nurse Educator ensured that annual competencies and new employee orientation were scheduled and conducted as needed. She created a curriculum and organized a new "Skill Fair" where nurses will demonstrate their knowledge and competency across various skill areas. She had an organized system of record keeping that included lists of employees/nurses who needed their annual competencies and/or monitoring of medication administration, and she informed the Charge Nurses of who was in need of training. When the Nurse Educator identified a training need, she ensured that training	

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		occurred through her ongoing communication with the nurse managers. The Nurse Educator had a wealth of knowledge and experience that she gladly shared with others, using positive, productive teaching methods. As represented by the facility in the POI, the Wound Care Nurse had a role and responsibility to ensure that nursing assessment and reporting protocols pertaining to wounds and wound care were implemented. The Wound Care Nurse and Infection Control Nurse worked in tandem to ensure that skin/wound infections were identified in a timely manner and interventions were implemented to treat the infection and reduce the likelihood that infection will reoccur. In addition, the Wound Care Nurse communicated and coordinated wound-related activities with the individuals' physician, physical therapist, nurse case manager, home nurses, and direct care staff members. She also convened weekly skin integrity meetings, which was an interdisciplinary review of tracking/trending of wounds, review of wound-related policy and procedure, discussion of high risk individuals, report of results of monitoring, and need for education and training. A facility like MSSLC would benefit from the Wound Care Nurse's experience and expertise. Interestingly, at MSSLC, the Quality Assurance Nurse was not a member of the Nursing Department, however, one would never know that from observation because the QA Nurse at MSLLC was a member of most, if not all, meetings that involved or required the presence of a nurse. The QA nurse participated in all aspects of quality oversight of the delivery of health care services to individuals at MSSLC. She conducted monitoring of assessments and care plans, reviewed incidents, injuries, and deaths, and, most importantly, ensured that follow-up actions occurred when problems, deficiencies, and/or lapses in the delivery of nursing supports and services were identified. In the meetings attended by the monitoring team, the QA Nurse's input was based upon her knowledge of the individuals and facility operations, her thoughtful examination of the delivery of nursing care, and her experience with taking large amounts of data and information and making it useful and relevant to the processes and individuals affected by the processes. Finally, the picture of nursing assessment and reporting protocols and processes at MSSLC would not be complete without the role and responsibilities of the RN Case Managers, Campus Nurse Supervisors, and Nurse Managers. These were the nurses who were responsible for data gathering and direct observations of individuals, documentation, collection, aggregation, and interpretation of these observations/data, and communication of these observations and data through assessments (verbal and written) to members of the individuals' personal support team (PST). If there are problems at this level of actual nursing assessment and reporting, there will be problems	

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		at each and every level as are referenced above in sections M1, M2, and M3 of this report.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	MSSLC had a health risk assessment rating tool and held regular health status team meetings. As noted in the baseline monitoring report, and as has continued, these processes had problems that resulted in what appeared to be incorrect ratings of risk for many individuals in important areas of risk and/or failure to increase level of risk in a timely manner such that the likelihood of harm and negative health outcomes was minimized. Therefore, this provision item was rated as being in noncompliance. MSSLC implemented a Health Risk Assessment Rating Tool to assess and identify each individual's levels of risk (no/low, medium, or high) across a number of particular areas: aspiration, choking, weight, cardiac, constipation, dehydration, diabetes, hypothermia, GI concerns, medical concerns, osteoporosis, respiratory, seizure, skin integrity, urinary tract infection, polypharmacy, challenging behavior, injury, and their overall risk level. These rating tools were completed in conjunction with individuals' PST meetings and annual PSPs. They were reviewed more often when an individual was assigned a "high" risk rating in one or more areas. The nursing department was assigned responsibility for completing the Health Status Risk Screening Assessments for 12 of the 18 risk areas. All five high health risks individuals reviewed had multiple risks related to their health, and two of the five individuals had behavior risks that compounded their health risks. The apparent correlations between the individuals' health and behavior risks, however, was not adequately identified and/or addressed by the HST. For example, a review of Individual #89's record revealed a significant correlation between his high risk for complications of diabetes and his mental health problems and behavior manifestations, however, the nature and impact of his personality disorders on his risk for complications related to his diabetes (and vice versa) was not adequately identified or reviewed by the HST. In June 2010, Individual #212 was identified as high risk for episodes of aspiration, choking, and behavior (problems). In August 2010, Individual #212's high aspiration and choking risks were reduced to medium without evidence that the changes in his behaviors (e.g., undesirable eating habits, resistance to use of adaptive equipment and/or staff assistance at mealtime, findings from meal observations) had been adequately incorporated into his health risk review and considered prior to decreasing his level of risk. One of the most important aspects of a health risk assessment process is that it effectively prevents the preventable and reduces the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. This feature of health risk assessment is in need of improvement at MSSLC. For example, in 2009, Individual #222 was diagnosed with	Noncompliance

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		intractable seizure disorder, osteoporosis, constipation, and myopia. At that time she was also described as non-ambulatory and with limited range of motion, spasticity, and bilateral pedal edema, however, Individual #222 was considered "low risk" on all measures of risk. Several months later, in April 2010, Individual #222's leg was fractured during bathing, and in May 2010, she was hospitalized for treatment of her seizures. Despite these negative health outcomes, at the time of this onsite review, Individual #222 was at high risk for seizure, but remained at medium risk for complications of osteoporosis and low risk for medical concerns and injury reportedly because she was considered "medically stable" and "tolerates all medications without complications." At the time of this onsite review, Individual #331 was designated at high risk for aspiration, and his problems and needs certainly justified this rating, however, he had many additional health problems and needs that were not adequately identified and addressed by his HST. For example, for several months preceding the onsite review, Individual #331 suffered recurrent problems related to alteration in skin integrity, which included decubitus ulcers, fungal infections, staphylococcus skin infections, and possible bacterial contamination (fecal) at his gastrostomy site, diarrhea, electrolyte abnormalities, and four-plus pitting edema, such that he was prescribed bed rest for days at a time. Clearly, these problems and risks did not add up to "stable" medical condition. At the time of the onsite review, Individual #331's 1/11/10 HMP failed to identify and address his high risk of aspiration and fell far short of identifying adequate and appropriate health care supports and surveillance to meet his needs and risks. At the time of the onsite review, Individual #155 was designated at medium risk for aspiration, choking, alteration in skin integrity, and injury. Since Individual #155's June 2010 Health Status Risk Screening Assessment, he had fallen several times, sustained serious injuries (e.g., head laceration that required staples, extensive bruising), flipped over his wheelchair while sitting in it (x2), suffered a head injury, and bit his staff member on her arm, which required emergency room treatment. Most of these incidents occurred while Individual #155 was on one-to-one level of supervision. Notably, despite these injuries and incidents while on enhanced level of supervision, Individual #155's level of risk of harm/injury was unchanged. Please also see section I of this report.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement	The administration of medication and the management of the medication administration system at MSSLC had improved since the baseline monitoring tour. As indicated in more detail below, additional work still needed to be done in the areas of proper completion of the MARs, management of the medications by the nurses, and in the oversight of	Noncompliance

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	nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	medication errors. Therefore, this provision item was rated as being in noncompliance. Observations of medication administration were conducted on Martin 5, Central 7, Central 8, and Whiterock 2. During all but one observation (the Central 8 observation), nurses properly washed and disinfected their hands prior to medication administration and between individuals, they identified the individuals receiving medications, they adhered to the accepted standards of medication administration, they did not initial medications prior to the individuals' receipts of medications, and they ensured individuals' privacy and dignity. All of the 30 individuals reviewed had a "SAM" (self-administration of medication) assessment and designation filed in their record. Many of the 30 individuals reviewed were designated as either not able to participate or in need of "verbal prompt" to participate in the self-administration of medication. During the observations of medication administration, all individuals were treated with respect, and individuals who had abilities to participate more, versus the individuals who had abilities to participate less, in the self-administration of medications were provided opportunities to access their personal medication boxes, dispense their medication(s) into medication cups, and take their medications with the fluids that were provided by the nurses. During the observations of two individuals (Martin) who received enteral administration of medication(s) and nutrition, their nurses checked the positions of the individuals and their feeding tubes, appropriately flushed and clamped their feeding tubes, and properly administered the individuals' medications in accordance with their physician's orders. According to the Chief Nurse Executive, since the baseline monitoring review, there had been changes in the processes that surrounded medication administration and review. There was an increase in the frequency of medication error meetings, changes in the analysis of medication error data, and assignment of reviews of data to designated nursing administration staff members. Notwithstanding these changes in process, as noted in MSSLC's baseline monitoring review, and as observed during this onsite monitoring review, the facility continued to implement a system of medication administration and reconciliation that led to medication errors and placed an overwhelming demand on the time and attention of staff members, including, but not limited to, nurses, pharmacists, managers, and administrators. At the time of the onsite review, medication carts were in disrepair, and bins were not adequate for the storage of individuals' medications. On every shift, nurses were required to count and record for every individual the number of pills on hand for each medication present in their bin(s). The only medications not included in the counts	

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		were stock and liquid medication(s). This was a time-consuming and overly burdensome task for the nurses, and it contributed to problems, such as low morale and job dissatisfaction. According to candid reports from several LVNs on duty at the time of the onsite review, the frequency of the nurse managers' reviews of Medication Administration Records (MARs) had increased from every two to three weeks to weekly, but nurses continued to be afforded opportunities to fill in missing initials without the event being considered a medication error. As noted in the baseline monitoring review, this practice was not in line with standards of practice and not consistent with the facility's report to the monitoring team that blanks (aka "holes") in the MARs were identified and recorded as medication errors. The review of 20 individuals' MARs for September 1 – 15, 2010 revealed problems of omissions and/or discrepancies in the MARs of three (Individual #6, Individual #77, and Individual #28) of the 20 individuals reviewed. These omissions and discrepancies included from one to five missing entries for psychotropic, bowel, and antibiotic medication(s), and vitamins/supplements during the two-week period. During the week of the onsite review, the Medication Error Committee did not meet. A review of the prior six months' meeting minutes, however, revealed that the committee identified and reported essentially the same findings month after month: 1. Martin had the highest number of errors, which was probably due to the number of medications dispensed and the number of individuals residing on the unit 2. the point of error was most likely at the point of administration and documentation (included blanks on the MARs) 3. the most frequent type of error was "wrong dose," (included omissions) 4. the shift with the most errors was the 2-10 shift, however data has recently shown a tie between 6-2 and 2-10 shifts for most errors 5. the single greatest and most likely cause of error was – "performance deficit." Although the Medication Error Committee had consistently reported "performance deficit" as the root cause of the problem, the strategies put forward to date to address the problem appeared to be misguided attempts to fix a broken system that needed change. As of the onsite review, medication error rates were not being calculated. It was reported to the monitoring team that the pharmacist planned to prepare and submit data to the committee, which will permit the calculation of these rates for review during future Medication Error Committee meetings.	

Recommendations:

1. Ensure that nurses consistently document health care problems and changes in health status, adequately intervene, and appropriately record follow-up to problems once identified.

2. Ensure that nursing assessments are complete and comprehensive.

3. Integrate the various medical order/stock health management plans (HMPs) into one person-centered HMP that is regularly reviewed, revised, and updated as individuals experience significant positive and/or negative changes in their health status.

4. Ensure that goals and service objectives are truly desired health outcomes of the individual as he/she is supported by his/her PST and not based upon narrow expectations of what can occur.

5. Incorporate the reviews of NIPs as part of the facility's overall plan/process to ensure that individuals' emergent/acute health risks are adequately identified and addressed.

6. Adopt a health risk screening tool and assessment process that includes the review and analysis of specific, objective, measurable data to codify/measure health risk and that the process is applied with preventing the preventable as a goal, versus reaction to the untoward event.

7. Ensure that the staff members who have been delegated health care duties are capable and competent to perform those duties.

8. Assign the Pharmacy and Therapeutics Committee the task of researching and proposing to the facility administrator several options for a more current medication administration system that supports medication administration practices, which are safe, accountable, and cost-effective.

9. Streamline "monitoring" and oversight activities to better utilize RNs and RN case managers' time in areas of mentoring, training, and assisting direct care staff members with delivery of health interventions to achieve positive outcomes for individuals.

10. Review and revise the monitoring strategy, including sampling and scoring methodologies, to better represent and improve the validity, reliability, and generalization of findings to the facility at large.

The following are offered as additional suggestions to the facility:

11. More carefully and thoughtfully consider the findings and recommendations of the QA Department, especially as they are identified by the QA Nurse, since they have a broader knowledge and understanding of patterns of problems and can identify practical, as well as innovative, solutions.

12. Consider implementing a process of shift-to-shift verbal communication report, including specification of what information must be

communicated during shift-to-shift reports.

13. Consider developing a Hospice Committee at MSSLC with nurses specially educated, trained, and competent to manage the care of individuals in need of end-of-life care planning and treatment.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o MSSLC Home Life and Training Manual, Nursing Services – 50, Medication Incident: Reporting and Investigating, 1/15/10 o MSSLC Pharmacy Policy and Procedure Manual, Pharmacy -47, Safe Medication Practices, 3/1/10 o MSSLC Home Life and Training Manual, Nursing Services – 68, DISCUS and MOSES Screening, 7/1/10 o MSSLC Pharmacy Policy and Procedure Manual, Client Management -22, Prescribing Psychoactive Drugs, 5/20/09 o MSSLC Policies and Procedures Manual, Committees and Councils- 33, Medication Error Review Committee, 9/9/10 o MSSLC Home Life and Training Manual, Medical Services -22, Adverse Drug Reaction Reporting, 9/19/08 o Psychoactive Medication Polypharmacy Review Committee Notes, 2/23/10, 4/27/10, 5/25/10, 6/29/10, 7/27/10 o Medication Error review Committee Summaries, 2/22/10, 4/1/10, 4/26/10, 6/29/10, 8/2/10 o Pharmaceutical Services, Summary of Meeting, 3/25/10 o Pharmacy Credits Data o Texas Department of State Health Services, Medication Audit Criteria and Guidelines Revised April, 2010 o Texas Department of State Health Services, Drug Audit Checklist, Revised April 2010 o Records for the individuals listed in Section L • Quarterly Drug Regimen Reviews • MOSES and DISCUS Scales <u>Interviews and Meetings Held</u>: o Matthew Okoro, Pharm.D., R.Ph., Pharmacy Director o Dolores Erfe, M.D., Medical Director o Norris Buchmeyer, R.N., Chief Nursing Executive o Multiple Physician staff meetings o Pharmacy and Therapeutics Committee meeting <u>Observations Conducted</u>: o Tour of MSSLC pharmacy

	Facility Self-Assessment: The facility's self-assessment POI for section N found all items to be in noncompliance. Progress had been made in some areas, such as verification of physician orders and timely completion of drug regimen reviews. In those areas where progress had been made, there was still work to do in order to comply with the requirements of the provision. In some areas such as development of an adverse drug reaction reporting and monitoring system, no progress has been made. Based upon observations, interviews, facility touring and review of many documents, the monitoring team agrees with the facility's assessment of non-compliance in all areas.
	Summary of Monitor's Assessment: Progress had been made with regards to verification of physician orders. Drug regimen reviews were consistently completed in all records reviewed. The quality of the reviews and value to the physicians were significant problems that require corrective actions. The MOSES and DISCUS scales were completed, but did not appear to register with the medical staff as valuable, based on the lack of completion of the tools. Much work is needed in the area of medication errors. The starting point must be acquiring valid and reliable data. The extent of medication errors at the time of the review was unknown. The facility had a procedure related to adverse drug reactions at the time of the visit, yet none were reported. Such systems provide useful data particularly in facilities where high risk drugs must be used.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing	The pharmacy was fully staffed with a pharmacy director, a new clinical pharmacist, two staff pharmacists, and four pharmacy techs. The clinical pharmacist had been working only two weeks at the time of the onsite tour and it was expected that she would be very involved in many of the clinical activities and drug review processes. The pharmacy director had recently implemented a double check system for processing pharmacy orders. A copy of the algorithm "Pharmacy Department New Medication Order Processing and Pharmacists Double Check" was reviewed with the director and is described below. When a medication order is received by the pharmacy, it is reviewed for adequacy of the order. This is referred to as the pre-screening process. -Pre-screening (Problem noted) o The order is received by the pharmacy. o A problem is identified, such as incomplete orders or a lack of a diagnosis.	Noncompliance

#	Provision	Assessment of Status	Compliance
	regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	o The 1st verification pharmacist contacts the MD for resolution. The pharmacist checks every hour until the issue is resolved. Clarification of orders is noted on the order sheet. -Pre-Screening (No Problems noted) o The order is received by the pharmacy and no problems are identified. o The pharmacy tech processes the order in WORx without generating labels. o The 1st order verification pharmacist verifies the medication order and generates labels. o The pharmacy tech fills the label with received medication order. o The 2nd verification pharmacist checks the filled medication order with the received medication order. o The pharmacy tech delivers the checked medication to the respective unit. The WORx pharmacy software provided checks for therapeutic duplication, drug interactions, allergies, and other issues upon entering a new medication. Clinical intervention sheets were generated for all pharmacy-physician interactions once the order was entered into WORx. The pharmacy director maintained a summary log of all clinical interventions and physician interactions. He reported that all clinical intervention sheets were provided to the medical director on a quarterly basis for review. He was not clear on how these data were used. He also maintained a log of orders processed through the pharmacy showing that the verifications were completed. Examples of the summary logs were reviewed at the time of the onsite visit. This practice had not been codified into policy and procedure to indicate the responsibilities of the pharmacists, medical director, and pharmacy director. The "Safe Medication Practices" procedure did not include the process of double checks being completed by the pharmacists. Upon touring the facility pharmacy, the monitoring team observed two to three filled orders lying on a table. The pharmacy director indicated that sometimes he would come out and see an order and would verify it. The process needs to be standardized such that each pharmacist is aware of who has the responsibility for completing the verification.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-	Drug regimen reviews were completed quarterly by clinical pharmacists. This was a substantial improvement from the baseline visit during which time DRRs were reported as not being done. The facility had received deficiencies during its 2009 licensing survey for failure to comply with Title XIX requirements for quarterly drug reviews. Although the reviews were completed, there were significant problems related to the content and physician response to the recommendations.	Noncompliance

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	therapeutic medication values.	According to pharmacy director, guidance for completion of the reviews came from Appendix A of the Health Care Guidelines and a worksheet provided to him by the medical director. The worksheet was not attached to any specific operational procedure and there were no facility-specific guidelines. When questioned about the origin of the worksheet, the medical director indicated that she was not familiar with the document. The drug regimen reviews included a summary of findings and provided recommendations to the PCP and psychiatrist when appropriate. The summary of findings included information on: • Presence of polypharmacy • Delivery device, dose, frequency, and route of administration • Potential drug interactions • Monitoring and evaluation of drug effectiveness, side effects, toxicity and adverse effects • Appropriateness of pharmacotherapy and consistency with psychotropic prescribing guidelines Recommendations were given related to therapeutic duplication, ordering of lab studies, dosage schedules, and appropriateness of indications. Thirty records were reviewed to assess compliance for completion of the drug regimen reviews. A subset of 53 drug regimen reviews was reviewed to determine compliance of the pharmacist in addressing the requirements for monitoring and physician compliance with consideration of the recommendations of the pharmacists. • In 30 of 30 (100%) records reviewed, there was timely completion of quarterly drug regimen reviews. • In 45 of 53 (85%) drug regimen reviews, there were either comments or recommendations from the pharmacist. • In 32 of 53 (64%) drug regimen reviews, there were specific recommendations from pharmacists that required physician response. • In 12 of 32 (38%) of drug regimen reviews, the physician agreed with the pharmacist. The following are examples of recommendations made by the pharmacists and physician responses: Individual #161 2/22/10 • Recommended checking the Vitamin D level • MD complied	

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		4/12/10 • Recommended decreasing the dose of Fosamax to 35 mg • MD did not respond 7/7/10 • Individual with a diagnosis of osteopenia and not osteoporosis • Recommended decreasing the dose of Fosamax • MD complied Individual #397, 2/23/10 • Individual with diagnosis of osteoporosis and schizophrenia • Recommended checking Vitamin D and obtaining EKG • MD complied Individual #111 3/15/10 • Recommended obtaining an annual EKG to comply with state guidelines • MD responded that anticonvulsant levels were monitored and EKG was not indicated Individual #249 4/29/10 • Recommended completing MOSES and DISCUS rating tools • MD responded MOSES and DISCUS were not indicated for individual Individual #104 • Recommended checking UA due to Tegretol • MD complied Individual #455 • Recommended reassessing indication for guanfacine; mood disorder is not an FDA or non-FDA labeled indication. • MD response was "it is an acceptable off-label pharmacotherapy for aggression." Individual #239 3/18/18 • Recommended obtaining annual EKG and FOBT • MD disagreed citing EKG not indicated and FOBT ordered annually Individual #134 3/4/10 • Recommended to obtain annual EKG, last done in 2007 and obtain stool guaic • MD responded EKG not indicated and FOBT ordered Individual #70 6/2/10	

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		• Recommended checking ammonia levels • PCP and psychiatrist responded not indicated Although the DRRs were being completed, there were significant issues with the process. The handwritten forms were difficult to read due to formatting and due to the presence of scattered notes. Most importantly, the handwriting was virtually illegible and notes, comments, and recommendations were not always distinguishable. During several discussions with the primary care physicians, the issue of the drug regimen reviews surfaced. In general, most physicians verbalized that they did not find the reviews to be helpful. They cited recurrent recommendations related to obtaining ammonia levels for individual receiving Depakote and the need to obtain an annual EKG for persons receiving carbamazepine. They had not received any guidelines indicating such requirements and had no knowledge of this particular monitoring as a standard of care. The drug regimen review has the potential to be a very robust tool in assisting physicians in drug management of the individuals. A comprehensive review may provide information on clinical outcomes relative to drug use. For example, a DRR may provide data on the frequency of seizures or behavioral outbursts so that correlation to drug changes can be noted. The medical staff should be allowed to have input in expansion of the DRR, such that it includes information relevant and useful in clinical practice. The medical director must work collaboratively with the pharmacy director to improve the quality of the drug regimen reviews and to ensure that the tool is helpful to the medical staff. It is also imperative the medical staff be aware of the criteria that are used in the DRR.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of	The quarterly drug regimen reviews included information on the use of polypharmacy as well as the risks associated with use of the new generation antipsychotic medications. Cholinergic burden was not addressed in the drug regimen reviews. The DRR worksheet provided instructions to use facility specific lab monitoring criteria or refer to the DSHS Medication Audit Criteria. MSSLC did not have a facility specific lab matrix independent of the recommendations included in the state-issued psychiatric guidelines. The DRRs included in the record sample had evidence that laboratory values were monitored and recommendations were made to the physicians. The drug regimen reviews did not produce any data for analysis related to	Noncompliance

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	benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	benzodiazepine use or adverse drug reactions associated with the new generation antipsychotics. Results of the reviews were not documented in the Pharmacy and Therapeutics Committee minutes. The facility implemented a Psychoactive Medication Polypharmacy Review Committee. Members included the medical, pharmacy, and psychology directors, all psychiatrists, and the PCPs. The committee met monthly to review and justify the use of polypharmacy. The committee was chaired by the medical director. The information in the minutes provided justification for use of polypharmacy. At times, the meeting participants were all members of the medical staff. Information (the justification) contained in the minutes was not included in the records of the individuals and, therefore, was only available to committee members. Data related to polypharmacy was also not documented in the Pharmacy and Therapeutics Committee minutes dated 3/25/10. While the process was helpful, a review of this structure was essentially the prescribing physicians monitoring their own practice. There was no evidence of collaboration between pharmacists and practitioners related to the use of stat medications. Improving the collaboration between the pharmacy department and physicians as it relates to monitoring the use of psychoactive drugs will require several actions related to the drug regimen reviews and the polypharmacy committee: • The quality of the drug regimen reviews must improve and this requires that the process be clearly codified in policy and procedure. With regards to the use of psychoactive medications, but not limited to those drugs, the following should be addressed: o The medication protocols or requirements should be clearly noted in policy and procedure. Laboratory and clinical monitoring should also be included. This may be accomplished by making a reference to an existing policy or procedure. o Drug levels and lab results should be documented in every review where appropriate. Abnormal values should be noted. o There should be a requirement to address the cholinergic burden of every individual. • The DRR should be used to produce aggregate data on specific performance measures of the agency. Polypharmacy data should be discussed at the Pharmacy and Therapeutics Committee Meeting. • There must be oversight of the Psychoactive Medication Polypharmacy Committee and data from that committee should also be discussed in the P&T	

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		Committee. • Additional functions of the P&T Committee will require meeting more frequently than twice annually. • Key data elements such as the use of polypharmacy should be forwarded to the facility's quality department. Consideration should be given to utilization of an external psychiatrist to participate in the Psychoactive Polypharmacy Committee in an effort to provide more objectivity.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	The format of the drug regimen reviews was revised in recent months, such that the prescribing physicians must indicate agreement or disagreement with the recommendations of the pharmacist. If the physician disagreed, an explanation was required on the form. As detailed in section N2 above, the physician agreed with the recommendation of the pharmacist in 12 of 32 (38%) DRRs that included recommendations. The disagreement may be partly due to a lack of shared information. This process was relatively new and no procedure had been developed to guide the process. Documentation of agreement or disagreement with the pharmacy recommendations was infrequently found in the progress notes.	Noncompliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The MOSES and DISCUS rating scales were completed in the records reviewed. There was little evidence that these tools were utilized in clinical decision-making. Both the MOSES and DISCUS scales were found in the records reviewed, when appropriate. The exact use, if any, of these side effect rating scales was not clear. For example: • Individual #397 had multiple completions of the MOSES instrument. Documents dated 1/6/10, 10/2/09 and 7/1/09 were completed by the nurse. There were no comments provided. The physician did not check any of the boxes, but signed the document. • Individual #111 had documents completed quarterly. On 7/8/09, the nurse documented teeth grinding, tongue movement, and self-injurious behavior. The physician checked no action necessary. On 1/15/10, bruising was documented. The physician signed the form without any other notation. • Individual #239 had quarterly assessments. On 5/12/10, a form was signed by the nurse and subsequently by the physician. The form was not completed by either. On another form, slurred speech and pedal edema were reported. The physician signed without any comment.	Noncompliance

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		Nursing Services Policy-68, MOSES and DISCUS Screening, provided guidance on completion of both documents. The facility's POI indicated that training for nurses had been completed.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The facility reported no adverse drug reactions. The documents given to the monitoring team included a written report of a physician meeting dated 6/7/10 listing adverse drug reactions as a topic for discussion. According to this document, the medical director contacted the office of the state pharmacy services director, and obtained a copy of the San Antonio State Hospital Pharmacy Policy and Procedure Manual. The manual described an adverse drug reaction as "any adverse symptom or sign that is unexpected reaction to a medication and that is response to a drug which is noxious and unintended and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function." The meeting notes further defined a reportable adverse drug reaction as "an adverse drug reaction that is unique serious, significantly complicates diagnosis, negatively effects prognosis or that occurs in a newly marketed product. Reportable adverse drug reactions shall be submitted to the FDA and the Executive Formulary Committee." Based on these definitions, the medical staff present at the MSSLC meeting were asked if they had any events that met these criteria during the time of employment at MSSLC. None of the physicians present reported cases that met this criteria. The conclusion was drawn that the facility had no reportable adverse drug reactions. The facility ADR reporting procedure dated 2008, provided directions for reporting ADRs to the FDA. The policy was in need of revision to better reflect the purpose of a reporting and monitoring program that includes: • Informing healthcare providers about ADRs to improve patient care • Identifying trends to prevent future ADRs • Providing the FDA and manufacturers with ADR reports when appropriate Key requirements of an ADR Monitoring and Reporting System include: • A program that is ongoing and concurrent with reporting of suspected ADRs by pharmacists, physicians, nurses, and patients • Identification and monitoring of drugs likely to cause ADRs • Use of probability scale to categorize each ADR • Investigation of suspected ADRs to determine the probability that the drug	Noncompliance

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		caused the symptoms • Severity established by a ranking system • Review of all ADRs by a designated committee, such as the P&T • Dissemination of information to health care professionals for educational purposes • Data collection, analysis, and trending both aggregate and individual data with results being incorporated into the agency's quality improvement program Revision of the facility's policy is needed and should reflect the fact that the reporting of adverse drug reactions is a facility wide process that should result in several ADRs being detected and reported yearly. Criteria for which of those ADRs should be reported to the FDA should be included in the procedure. Implementing an effective ADR reporting and monitoring system that provides useful information for the facility will require training of all healthcare personnel.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility completed one drug utilization evaluation (DUE) on carbamazepine. The DUE was completed on 3/29/10 and presented at the September 2010 P&T Committee meeting. The facility had not developed a procedure to address the requirements of the Pharmacy and Therapeutics Guidelines of the Health Care Guidelines. The process for completion of the DUE was not in compliance with the requirements of this provision item. The following is a summary of the carbamazepine DUE presented during the P&T Committee meeting attended by the monitoring team: The objective of the review was to monitor the appropriate use of carbamazepine in the areas of brand versus generic selections, indications, appropriate dosing, other anticonvulsant, drug-drug interactions, contraindications, drug tapering, and documented side effects. <u>Methodology</u> The audit was conducted by the pharmacy director and completed on all 47 individuals receiving carbamazepine. Individuals were identified through the pharmacy database, and data were obtained through individual chart reviews. <u>Data Analysis</u> Individuals with inappropriate indications: 0/47 (0%) Individuals with inappropriate dose: 0/47 (0%) Individuals with the same class of drug for same indication 16/47 (34%) Individuals with medication being tapered: 2/47 (4%)	Noncompliance

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		Individuals with medication contraindication 0/47 (0%) Individuals with documented side effects: 1/47 (2%) Individuals with noted drug interactions: 0/47 (0%) The one side effect, neutropenia, was reported to have resolved. <u>Conclusion:</u> The conclusion drawn from the DUE was that the use of carbamazepine was consistent with the DSHS/DADS Drug Formulary dosage guidelines, and in line with the literature approved drug monograph for appropriate use. <u>Recommendations</u> Continue with the current carbamazepine regimen guideline. During the P&T Committee meeting, the medical director stated that she assumed DUEs were being completed monthly by the pharmacy director. The pharmacy director indicated that no schedule had been determined and, therefore, DUEs could not be completed. The P&T Committee meetings were held only twice a year. When asked by the monitoring team about the requirements for P&T meetings, the medical director responded that state office had directed the facility not to make any changes in the meeting process. The P&T meeting minutes dated 3/25/10 reflected that response. There was clearly a disconnect between the medical director and the pharmacy director, and the outcome was the failure to execute the requirements for completion of DUEs. As outlined in Appendix A of the Pharmacy and Therapeutics Guidelines, a DUE system should be established through the P&T Committee. The committee should develop a schedule that includes the medications to be reviewed, the timeframe for review, the indicators, data collection tools, determine sample size and thresholds for compliance. High risk and high use drugs should be given priority for review.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and	The facility collected data on medication errors and reviewed that data as part of the Medication Error Review Committee. The system, however, had significant flaws in data collection, analysis, and corrective actions. The Medication Error Committee reviewed all medication errors within the facility on a monthly basis starting in January 2010. The medical director chaired the committee. Nursing services collected data on medication errors and forwarded it to the chief nurse	Noncompliance

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	potential medication variances.	executive. The CNE reviewed the data and presented information at the MERC. Data for 2010 are summarized in the table below. Although the data presented in the table represent a relatively low level of errors, as indicated in the paragraphs below, numerous problems in the way MSSLC collected medication error data made these data invalid, unreliable, and, therefore, unusable.	

Medication Errors 2010						
	Jan	Feb	Mar	April	May	June
Total Errors	12	25	19	8	17	14
Required Monitoring	0	0	1	0	0	4
Serious Errors	0	1	0	0	0	0

The most frequently occurring errors were those of administration. The majority of those were omissions. Errors involving the wrong individual and wrong drug also occurred. One serious error occurred in February 2010 and involved an individual being given another individual's medications. The individual was hospitalized, but suffered no adverse sequelae. Several errors were reported that required monitoring to determine that no harm occurred. The numbers recorded likely represent under reporting and this was acknowledged in several MERC meeting summaries.

There were several key issues related to the medication use system for the facility and the medication error system:

- The medication system at MSSLC utilized a unit dose system. Medications were delivered to the homes weekly in carts. Each individual had an individual drawer that contained his or her medications. At the end of the fill cycle, the med carts were returned to the pharmacy. Overages were medications returned to the pharmacy.
- It was reported that significant numbers of medication were returned to the pharmacy without explanation. MERC summary notes from 2/22/10 documented that overages were occurring and explanations were needed. The MERC summary dated 4/26/10 documented, "the number of overages was discussed in committee and is of great concern." At the time of the site visit, no reconciliation had been completed to determine the actual number of variances that occurred.
- There were other indicators that omissions were greater than reported, such as blanks found in the MARs.

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		• During the onsite visit, the monitoring team also advised the chief nursing executive that the variance rates were incorrectly calculated because the number of errors was being divided by the census of the facility. The error rates reported in meeting summaries should have called for serious and immediate action. The error rates should be based on the opportunities for error (number of errors/opportunities for error) x 100. • The Pharmacy and Therapeutics Committee minutes dated 3/25/10 did not document any discussion related to medication errors. The meeting attended by the monitoring team did not include any discussion or analysis of medication error data. The only issue discussed during the meeting related to the overages. Review and analysis of medication errors is usually a fundamental responsibility of a facility's Pharmacy and Therapeutics Committee. Many steps are needed to strengthen the medication error reporting and monitoring system. The persons responsible are in need of training on proper data collection and analysis. The most basic metric of the system, the medication error rate, was improperly calculated and this error went undetected. It is the analysis of reliable and valid data that should drive the corrective actions for the facility. The medical, nursing and pharmacy departments will require assistance from quality assurance on problem solving methodologies and data integrity in order to resolve the outstanding issues.	

Recommendations:

1. The verification and double check procedure should be included in policy and procedure of the department.

2. An ADR reporting and monitoring system should be developed.
    a. This is a comprehensive program that requires reporting by all healthcare practitioners, not just pharmacy staff.
    b. A data collection tool is needed to assist staff in detecting and reporting suspected ADRs. The tool should include a probability scale, a severity scale, and individual outcome thresholds (i.e., the clinical outcome for the individual).
    c. The outcome thresholds should be used to conduct intense case analysis.
    d. All data should be reviewed by the P&T Committee and submitted to the facility's quality department.

3. Additional work is needed in the area of medication errors.
    a. All errors, potential and actual, must be reported.
    b. All medications that are returned to the pharmacy must be reconciled.
    c. If no explanation is found for the returned medication, it should be considered an omission.
    d. Data should be analyzed for trends and corrective actions taken.

e. Data should be provided to the facility's quality department for analysis.
f. Performance improvement projects should be chartered for problems that are not amenable to appropriate corrective actions.
g. The medical director should assume an active role in this process.

4. The Drug Use Evaluation system must be developed to fulfill the requirements of the Health Care Guidelines. The Pharmacy and Therapeutics Committee should provide oversight for the system. The medical director should have an active role in the process including a review of data prior to presentation at the P&T Committee meeting.

5. The agency's Drug Regimen Review System must be evaluated. The reviews, if more substantial in content, could provide valuable resources to clinicians. The revision process should include input from the medical staff. The use of computer software for completion of these reviews should be explored. State criteria used in completion of the reviews should be shared with the medical staff.

6. The Polypharmacy Review Committee should ensure that clinical justification for medication use be accessible to those persons that have a need to know. Documenting clinical justification in the records would be adequate to achieve this goal. The committee must have some oversight since the prescribing practitioners are reviewing their own justifications. This could be accomplished through contracting with a psychiatrist to participate in the monthly meetings to serve as an objective outsider. Clinical justification and polypharmacy data should be reported to the agency's quality department.

7. The function of the Pharmacy and Therapeutics Committee is to serve in an evaluative, educational, and advisory capacity to the medical staff and organizational administration in all matters pertaining to the use of drugs in an effort to promote the rational and safe use of drugs. The facility must reevaluate the structure and function of the committee and require more frequent meetings.

8. The administrative team must insist on collaboration between the medical and pharmacy departments. The pharmacy director should receive adequate supervision and support in carrying out his duties and responsibilities.

The following are offered as additional suggestions to the facility:

9. The results of the side effect rating tools should be incorporated into the evaluation and treatment decisions for medical, psychiatry, and neurology practices. The medical director should work with the nursing department to ensure that more meaningful reviews are completed. The medical director must also convey to the medical staff the importance of adequate monitoring for side effects when individuals are treated with antipsychotics and AEDS. All staff who either complete or use the side effects rating tools should receive adequate training on the completion and use of the instruments.

10. Staff responsible for quality improvement and performance improvement initiatives should be provided appropriate training on data integrity, data analysis, and performance improvement methodology.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **<u>Documents Reviewed</u>:** o List of PNMT members o Continuing education documentation for PNMT members and QA monitor for Provisions O, P, R o CV for Gary Sandler, MOT, OTR, Interim Habilitation Therapies o Physical Nutritional Management policy #012, 12/17/09 o Client Management Policy #34, Reporting Choking Incidents (3/16/10) o Nutritional Management Policy #013, 12/17/09 o At-Risk Individuals Policy #006, 10/05/09 o QA monitoring forms for Section O, June/July/August 2010 o List of individuals with PNMPs o PNMPs (approximately 223 submitted) o PNM Clinic Summaries submitted o Individuals with Wheelchairs Used for Primary Mobility o Individuals with Wheelchairs for Transport 8/17/10 o Habilitation Therapy Services Database, orthotics 8/6/10 o Habilitation Therapy Services Database 5/5/10) o ER Visits 1/1/10 to 8/13/10 o Hospitalizations 1/1/10 to 8/13/10 o PNMT documentation for Individual #331 o List of Modified Barium Swallow Studies (MBSS) July 2009 – December 2010 o MBSS reports and associated documentation submitted o List of Bedside/Chairside Dysphagia Evaluations o Dysphagia Consultation reports for: • Individual #41, Individual #519, Individual #171, Individual #331, Individual #491 o List of Individuals Monitored Last Quarter o NMT meeting minutes: 1/21/10, 2/11/10, 3/11/10, 4/30/10, 5/28/10, 7/8/10, and 7/22/10 o NMT Reports submitted o List of individuals with enteral nutrition o Wound Care Data o List of individuals with Choking incidents o Choking Incidents o HST Risk Assessments – List of Risk Levels (Aspiration), 8/17/10 o Health Status List 8/17/10 o Health Risk Assessment Tool Ratings o Pressure Ulcers from August 2009 to 8/16/10 o BMI Equal or Less than 20

- BMI Equal to or Greater than 30
- Impactions list
- Weight Loss of 10% or more in six months
- Communication Master Plan Database (diet order downgrades)
- Alpha Client List with admission dates (8/24/10)
- Dining Plans for:
  - Individual #35, Individual #589, Individual #144, Individual #523, Individual #148, Individual #438, Individual #41, Individual #216, and Individual #488
- Dining Plan inservice training staff sign in sheets
- Other Dining Plans submitted (55)
- Fall incidents data sheets
- List of individuals with falls in the last 12 months
- NMT Agenda 9/14/10
- Nutritional Management Team Follow-Up form
- OT/PT Evaluations for the following:
  - Individual #431, Individual #244, Individual #122, Individual #578, Individual #17, Individual #269, Individual #498, Individual #108, Individual #218, Individual #581, Individual #110, Individual #480, Individual #310, Individual #328, and Individual #297, Individual #139, Individual #135, Individual #408, Individual #392, Individual #182, Individual #519, and Individual #240
- PSPs and Addendums for the following:
  - Individual #498, Individual #49, Individual #265, Individual #240, Individual #1, Individual #257, Individual #100, Individual #433, Individual #449, Individual #182**,** Individual #392, Individual #135, Individual #269, Individual #139, Individual #581, Individual #491, Individual #519, and Individual #218.
- New Employee Orientation training curriculum
- Sign in sheets for Oral Care and Choking Risk Inservices conducted for PNMPCs
- Personal Record documents including: Personal Support Plans and Addendums, Integrated Progress Notes (previous three months), Physicians Annual Medical reviews, Active Problem list, Significant Past Medical History, HST Assessment Tools, Comprehensive Nursing Assessment, Quarter Nursing Quarterly Assessments for the last PSP year, Habilitation Therapies section, PNM Monitoring for the last six months year, Mealtime Monitoring for the last six months, Communication monitoring forms for last six months
  - Individual #35, Individual #256, Individual #488, Individual #196, Individual #322, Individual #41, Individual #216, Individual #438, Individual #148, Individual #435, Individual #411, Individual #347 Individual #523, Individual #405, Individual #268, Individual #164, Individual #431, Individual #589, Individual #59, Individual #486, Individual #331, and Individual #212

Interviews and Meetings Held:

- Gary Sandler, MOT, OTR/L, Interim Habilitation Therapies Director
- Doris Ricketts, OTR, MBA

	o Lisa Finley, COTA/L o Pam Harlan, COTA/L o Sandra Opersteny, PT, MEd o Sandy Leggett, PT o Betty Cotton, PTA o Cynthia Buchmeyer, PTA o Robert Morgan, ATP o Cara Mattson, MS, CCC/SLP o Jean Reboli, MS, CCC/SLP o Deann O'Lenick, MS, CCC/SLP o Jeaneen Abram, LSLA o Keri Perkins, RD/LD o Jennifer Capers, RD o Elaine Pruitt, Speech Technician o Various Direct Support Staff in homes and day program areas **Observations Conducted:** o Living areas o Dining rooms o Day programs o Habilitation Therapies clinic areas o PNMT assessment o PNMP Clinic o Wheelchair Clinic
	Facility Self-Assessment: MSSLC's self-assessment identified noncompliance for all items of this provision. Per the POI reviewed, the primary issues cited included staff vacancies and the development of new processes as the rationale for unsuccessful completion of the action steps outlined. This self-assessment was generally consistent with the monitoring team's assessment. It is recommended, however, that the self-assessment be broken down into smaller action steps for ease of implementation, but also as a way to measure forward progress in smaller increments of success. The current use of the monitoring team's form developed for assessing the system, was currently being used to assess documentation and outcomes for individuals through QA. This was an inappropriate use of this tool. The self-assessment and QA assessment should be closely linked. The POI Action Steps generally examined system issues. Another mechanism to track individual outcomes should be implemented as a means to assess how well the systems work and where there are strengths and weaknesses.

	Summary of Monitor's Assessment: The process used to establish health risks was inconsistent across the HST and NMT. Different screening tools were used and there was little to no integration across these two systems. By report, the NMT had begun to utilize the HST ratings, but there was no evidence of this practice contained in the minutes submitted. This system, as used statewide, was ineffective and did little to heighten the awareness of potential harm to those individuals with complex and serious health risk concerns or to enhance the intensity and frequency of intervention, review, and monitoring. During the week of this onsite review, it was understood by the monitoring team that a new system to assess health risk had been, or was soon to be, developed. This will be reviewed upon implementation during subsequent onsite visits. There was a new draft policy developed by the state to provide for a Physical Nutritional Management Team (PNMT) with an implementation date of 9/1/10. A PNMT assessment for Individual #331 had been initiated on 8/31/10 and a follow-up was conducted on 9/16/10 during this onsite review and was observed by the monitoring team. The interaction, discussion, and analysis noted on 9/16/10 by the monitoring team showed promise of improved integration and problem solving. There was participation by all team members, including the direct support staff. The effectiveness of this new process will be further evaluated in subsequent reviews. Unless an individual participated in direct therapy, there was no consistent interval of review of other supports for those individuals who presented with PNM health risk indicators by professional staff. In the case that an individual participated in direct therapy, a monthly progress note was written, but functional and measurable goals were not identified in all cases. There was no system of monitoring of PNMP effectiveness for those at highest risk. When present during observations by the monitoring team, PNMP Coordinators and the PNMP supervisor, Pam Harlan, COTA, were observed to intervene appropriately when the PNMP, particularly the dining plans, were not properly implemented by direct support staff. Home supervisors were not observed to intervene unless prompted to do so. There was no mechanism to track training related to, communication of, or follow-up to concerns noted during monitoring. There was no mechanism to track data for system analysis in order to focus training and coaching. The NMT did not utilize PNMP monitoring information in their reviews. The NMT did not specifically review aggregated findings across homes for trend analysis to drive system change and training. There was no system in place to conduct routine review in order to determine if interventions had a positive outcome on an individual's health status. There was also no review of the overall incidence of health concerns, such as aspiration pneumonia, use of bowel management aides, weight loss/gain, falls, fractures, and so forth over time to address system outcomes as a result of interventions and supports. Based on observations of individuals across a variety of homes, particularly during meals, there continued to be concerns for staff implementation of interventions and recommendations outlined in the PNMP.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>O1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan (“PNMP”) of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual’s annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual’s ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals’ physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed,</td><td>Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).

Minutes from the Nutritional Management Team (NMT) meetings held monthly were dated 8/13/09 to 7/22/10. Per the minutes the core members of Nutritional Management Team (NMT) listed included the following:
• Lisa Finley, BAS, COTA
• Anita Lane, OTR/L
• Margaret Farrington, OTR/L (PNM Supervisor)
• Kim Henderson, SLP
• Keri Perkins, RD, LD
• Rosemary Roberts, RN
• Delores Erfe, MD

Core member attendance for meetings held in 2010 to date per minutes submitted was as follows:

<table>
<tr><th>Date of Meeting</th><th>MD</th><th>RN</th><th>OTR</th><th>SLP</th><th>RD</th><th>PNM</th></tr>
<tr><td>1/21</td><td></td><td>X</td><td>X</td><td></td><td>X</td><td></td></tr>
<tr><td>2/11</td><td>X</td><td></td><td>X</td><td></td><td>X</td><td></td></tr>
<tr><td>3/11</td><td></td><td>X</td><td>X</td><td></td><td>X</td><td></td></tr>
<tr><td>4/30</td><td></td><td></td><td>X</td><td>X</td><td>X</td><td></td></tr>
<tr><td>5/28</td><td></td><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>7/8</td><td></td><td>X</td><td>X</td><td></td><td>X</td><td></td></tr>
<tr><td>7/22</td><td>X</td><td></td><td>X</td><td></td><td>X</td><td></td></tr>
</table>
X= team member present for all or a portion of the meeting

Additional staff generally also in attendance were identified as non-members and included a variety of physicians and nurses. Occasionally, others were listed as attending: Jean Reboli, MS, CCC/SLP; Doris Ricketts, OT/L; Kim Kirgan, QA; or PNM Coordinators. The interim Habilitation Therapies Director was listed as attending one meeting on 7/22/10. The primary SLP, Kim Henderson was no longer employed at MSSLC since August 2010. On average there were 16 staff who participated in the meetings. There were no physical therapy members. The team chairperson was Lisa Finley, BAS, COTA. At the time of this onsite review, Doris Ricketts, OTR/L had been recently appointed as the new Chairperson, and the previous chair attended as an assistant to her. Ms. Rickets chaired her first meeting during the week of this onsite review. That meeting was observed by the monitoring team. During that meeting both dietitians, Keri Perkins,</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	RD/LD and Jennifer Capers, RD, as well as two of the SLPs, Jean Reboli, MS, CCC/SLP and Cara Mattson, MA, CCC/SLP, attended the meeting in addition to a number of nurses and physicians. A new format had been developed to document findings and discussion at these meetings. A risk level was assigned (no criteria listed) and follow-up occurred as follows: • High Risk = monthly review • Medium Risk = at least annually • Low Risk = as needed (PRN) Meeting minutes had previously been maintained by the now former committee Chairperson, Lisa Finley, COTA. The format of the minutes was consistent across each meeting and included a topic, discussion and disposition for each individual reviewed. The average number of individuals reviewed was 15.75 across the meetings held in 2010. There were approximately 62 individuals reviewed during 2010 to date per the meeting minutes submitted. There were 22 individuals reviewed twice during that period and seven individuals reviewed three times (Individual #544, Individual #216, Individual #521, Individual #375, Individual #359, Individual #83, and Individual #511). All others were reviewed one time during that period. There were approximately 126 reviews conducted. Discussion of individuals related to categories as follows: • Annual Review: 22% • Follow-up from previous meeting: 21% • Pneumonia/Aspiration pneumonia: 12% • Review based on Risk Screens: >1% • MBS: 20% • PEG tube placement: 5% • Choking/Aspiration: 4% • Weight: 4% • GI: 4% • Post-hospitalization: 2% • Cancer/terminal illness: 4% • Other: 3% It was not possible to verify the qualifications and experience of all members based on the documentation submitted. Licenses for team members were not submitted. Verification of licensure for one nurse, Norris Buchmeyer, was submitted, however he was not listed as an attendee for any meetings held in 2010. CVs for several physicians were submitted including: Victor L. Vines, MD, who was Board certified in Obstetrics and Gynecology; Jose	

#	Provision	Assessment of Status	Compliance
		J Ruiz-Cales, MD, with experience also in obstetrics and gynecology as well as family medicine; Liesl Schott, MD, with background in general surgery, ENT, and as a licensed general practitioner; Yenni L. Michel, DO, with background in family practice; Christopher Ellis, MD, who was Board certified in internal medicine; and Gabriel Tarango, DO, with a background in family medicine. A CV for Gary Sandler, OTR was submitted as well. He was serving as the interim Habilitation Therapies Director for several months in concert with his duties as Director at the Richmond State Supported Living Center where he had worked since February 2008. No other CVs were submitted for committee members, so it was not possible to verify their experience. With the exception of Dr. Michel and Dr. Ruiz, each of the physicians had listed extensive continuing medical education hours in the last year. Dr. Michel had participated in a medical residency program and was not required to obtain continuing education credit hours. There were no hours listed for Dr. Ruiz, per the documentation submitted. Jean Reboli, MS, CCC/SLP had attended a two hour course, "Issues in Nutritional Management." With the exception of the physicians, there was no evidence that other members had obtained PNM-related continuing education. A two-hour course for Ms. Reboli, the SLP was inadequate. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** Per state policy, meetings were to be held at least monthly, with additional meetings held related to the following: eating/health problems, changes in risk level by the HST, after esophagrams or other medical or diagnostic tests, before finalizing treatment decisions, to address follow-up activities, and at any phase in the Nutritional Management process. Based on a review of NMT meeting documentation, it was noted that this group had typically met one time monthly for the last six months (no meeting was held in June 2010, but two meetings were held in July 2010). There was no evidence that a meeting had been held in August 2010 because no minutes were submitted. There was no evidence that the team convened for any additional meetings to address other issues that came up in the interim.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has	**Standard: A process is in place that identifies individuals with PNM concerns.** The process used to establish health risks was inconsistent across the HST and NMT. Different screening tools were used and there was little to no integration across these two systems. By report, the NMT had begun to utilize the HST ratings, but there was no evidence of this practice contained in the minutes submitted. This system, as used statewide, was ineffective and did little to heighten the awareness of potential harm to those individuals with complex and serious health risk concerns or to enhance the	Noncompliance

#	Provision	Assessment of Status	Compliance
	difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	intensity and frequency of intervention, review, and monitoring. During the week of this onsite review, it was understood by the monitoring team that a new system to assess health risk had been developed. This will be reviewed upon implementation during subsequent onsite visits. There was a new draft policy developed by the state to provide for a Physical Nutritional Management Team (PNMT) with an implementation date of 9/1/10. A PNMT assessment for Individual #331 had been initiated on 8/31/10 and a follow-up was conducted on 9/16/10 during this onsite review and was observed by the monitoring team. PNMT members present during this assessment included the following: Dawn Price RN; Jennifer Capers, LD; Keri Perkins, RD/LD; Deann O'Lenick, MS, CCC/SLP; Sandra Opersteny, PT; Pamela Harlan, COTA, Margaret Farrington, OTR; and Doris Ricketts, MBA, OTR/L. Additional attendees included Kayla Mayfield, direct support staff for Individual #331; Kim Kirgan, Assistant QA Director; and the monitoring team. Concerns addressed on this date included lab results, and tolerance to a newly prescribed formula administered via gastrostomy tube. Individual #331 presented with a significant history of numerous PNM-related concerns. Per his OT/PT Update assessment on 11/9/09, Individual #331 had a resolved history of anemia, GE reflux, pneumonia, and emesis. His Nutritional Risk Screening level was medium due to dysphagia and low weight. Though he previously ambulated independently and performed stand pivot transfers with a helmet, as of the 2009 update assessment, Individual #331 was no longer independent, requiring a gait belt and a wheelchair for mobility away from his home. Per progress notes, he had a PEG tube placement on or around 6/23/10. The exact date was not identified from the documentation submitted. Progress notes prior to 7/1/10 were not submitted and the NMT meeting minutes did not document the date of placement. His PNMP had not been updated during that time, however, as it continued to reflect that he received oral intake per the plan submitted as current. The timeline for review of Individual #331 by the NMT was as follows: • 10/20/09: Review post-hospitalization for pneumonia and weight loss. He was assigned high nutritional risk with planned follow-up in one month. • 11/12/09: Reviewed for follow-up of weight loss and meal refusals. Weight gain of .4 pounds, though by report his appetite was increased. He continued on Megace for "anorexia." Risk level reduced to medium with follow-up in three months. • 2/11/10: Follow-up review. Weight gain of less than one pound in nearly four months since October 2009 with caloric intake of 5475. At that time, staff reported that he was having difficulty with transfers and ambulation.	

#	Provision	Assessment of Status	Compliance
		Recommendations were to continue with the current plan of mealtime assistance by familiar staff and physical therapy evaluation of transfers and ambulation. There was no evidence of implementation of these in the documentation submitted, however. There were no consult reports by PT submitted and the PSP Addendum meeting discussion record did not report any information related to either of these recommendations. • 4/30/10: Follow-up post-surgery on 3/12/10 when his right testicle was removed for possible testicular cancer found to be benign. There had been no follow-up after the surgery by the NMT until this date, approximately one and half months later. Though there was a reported weight gain of 11 pounds, he reportedly continued to refuse meals. Recommendations were to include a liquid diet with supplemental solids. There was no evidence of a PSP Addendum meeting to discuss implementation of these recommendations. The NMT did not discuss Individual #331's mobility status or any findings of the evaluation recommended over two months earlier. Follow-up was recommended in two months. • 5/28/10: Review occurred in one month rather than two due to meal refusals and dehydration with IV hydration ordered for three days. MBSS ordered with follow-up by the NMT indicated in one month and nutritional management risk level was adjusted back up to high. Again there was no evidence of review of his mobility status during this review. • 7/8/10: There was no further review by the NMT until this date despite findings of MBSS on 6/9/10, recommendations for nothing by mouth, and PEG tube placement. Silent aspiration was noted in this study. The SLP indicated that the NMT would review at the next meeting. There was no meeting held in June 2010 and there was no interim meeting held to review Individual #331's continued significant change in health status. There had been a PSP Addendum meeting on 6/10/10 to discuss these and the PST, including Individual #331's father/guardian, approved of this procedure. Only the team physician and nurse attended the PST meeting from the NMT. A PNMP Coordinator also attended, but no professional staff was represented such as the OT, PT, SLP or dietitian. Per the PSP Addendum on 6/30/10, Individual #331's HST risk for aspiration was not adjusted to High until 6/24/10, but he was returned to medium per medical on 6/30/10, despite the findings and recommendations of the MBSS conducted on 6/9/10. • August 2010: No meeting minutes were submitted though these had been requested by the monitoring team. • 9/14/10: Further discussion regarding chronic edema, skin integrity concerns and low albumin in August and September. A special formula had been ordered.	

#	Provision	Assessment of Status	Compliance
		It was of great concern that this individual, who was clearly at high risk, continued to present with ongoing concerns since prior to October 2009, and yet the interval of review and intensity of supports by the NMT was inadequate. While it was positive that he was being evaluated using the new PNMT process, it was of concern that no further assessment would have been conducted otherwise. The interaction, discussion and analysis noted on 9/16/10 by the monitoring team showed promise of improved integration and problem solving. There was participation by all team members, including the direct support staff. The effectiveness of this new process will be further evaluated in subsequent reviews. In addition, per a list submitted, there were 16 individuals who experienced 20 choking events in the last two years. Individual #41 experienced five such events during that period and ultimately died as a result of a choking event on 8/21/10. Prior events occurred on 1/9/09, 5/6/09, 9/9/09, and 1/12/10. In some cases following a choking event, a dysphagia consult was completed by the SLP, however in the case of these 20 events listed in the last two years, 54% of the individuals did not receive this assessment. When it was conducted, it was not in conjunction with any other professional staff but in isolation by the SLP only. In some cases there was a consult in conjunction with a MBSS scheduled as a result of choking, but this generally occurred well after the actual choking incident. Also in some cases there was no NMT review of these events. The intervals for consultation and NMT review were as follows:	

Name	Date of Event	Date of Consult	Date of NMT Review
Individual #41	1/9/09	1/21/09	No minutes
Individual #431	2/2/09	none	No minutes
Individual #411	3/10/09	3/10/09	No minutes
Individual #41	5/6/09	5/7/09	No minutes
Individual #509	8/13/09	none	9/10/09
Individual #41	9/9/09	9/13/09	none
Individual #256	9/9/09	9/10/09	9/10/09
Individual #75	10/15/09	10/19/09	none
Individual #161	11/16/09	11/18/09	12/15/09
Individual #212	11/29/09	none	none
Individual #41	1/12/09	1/14/10	none
Individual #199	1/18/10	none	3/11/10
Individual #546	2/10/10	2/10/10	3/11/10
Individual #164	2/18/10	none	3/11/10
Individual #585	3/30/10	none	5/28/10
Individual #36	3/31/10	none	none

#	Provision	Assessment of Status	Compliance

Individual #586	4/19/10	4/19/10	5/28/10
Individual #14	8/10/10	8/11/10	No minutes
Individual #41	8/21/10	deceased	deceased
Individual #196	8/23/10	none	No minutes

Some of the NMT reviews were actually related to follow-up to a swallow study only and the choking incident was not mentioned. It was of concern that there appeared to be no sense of urgency about the need to review these case and to conduct close monitoring and follow-up after implementation of changes to the plans designed to ensure their continued safety.

- Individual #431was also listed with another choking event on 6/1/10. No documentation was submitted in regard to this as requested. There was no evidence of NMT review through 7/22/10.
- Individual #589 had a choking incident on 7/4/10 and there was no documentation submitted.
- Individual #196 was known to have had a second choking incident the week prior to this onsite visit by the monitoring team.
- Individual #201 also had a choking event during the week of the onsite visit and was hospitalized.

Meeting minutes were not submitted after 7/22/10, so it was no known if these three individuals were reviewed by the NMT. There did not appear to be a reliable means to track the incidence of choking at MSSLC as each of the lists submitted were different and the dates of the events listed were inconsistent with the incident reports reviewed.

Standard: Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team.

Individuals who received direct and indirect PNM and OT/PT supports received annual OT/PT assessments in addition to medical, nursing, and nutritional assessments provided annually to each individual. Assessment was not specifically driven by level of health risks. These were discipline-specific assessments with the exception of the OT/PT assessments, and little collaboration at the time of assessment was noted among professional staff for any individual, and certainly not for those at highest risk. As described above, there was a new draft policy developed by the state to provide for a Physical Nutritional Management Team (PNMT). This was to include a comprehensive assessment by the team that included OT, PT, RD, SLP, and nurse. It was not clear if other

#	Provision	Assessment of Status	Compliance
		team members were identified because the policy was in draft form and staff were instructed to not yet provide a copy to the monitoring team. Further review of this area will be needed as this system evolves.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	**Standard: All persons identified as being at risk and requiring PNM supports are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).** There were approximately 221 individuals who were listed with PNM needs and approximately 204 listed as not in need of PNM supports and services. There were approximately 223 individuals with PNMPs submitted as current in response to monitoring team's request completed Physical Nutritional Management Plans (PNMPs) for all individuals with identified needs. Many individuals presented with PNM-related concerns in the last 12 months and a number had multiple concerns. It appeared that they had been provided a PNMP. The facility-wide system, HST, of risk did not appear to consider actual incidence of a concern, but rather the designation of risk appeared to be more driven by meeting frequency rather than actual risk or incidence. These risk designations also did not drive review by the NMT and there was little integration that team with the HST. Per the HST risk levels, there were only 19 individuals with a high risk designation in any area per the list submitted dated 8/17/10 that included 382 individuals. These included Individual #41 (choking), Individual #560 (seizures), Individual #222 (seizures), Individual #59 (respiratory), Individual #448 (constipation), Individual #359 (GI concerns and skin integrity), Individual #89 (diabetes), Individual #281 (polypharmacy), and Individual #212 (aspiration, choking, challenging behavior). All others were considered to be at high risk related to challenging behaviors only. The NMT used an entirely different method to designate risk and it did not correlate with those used by the HST. It was understood that the HST system and was under current revision to address these issues and further review of integration of these two systems will be indicated in the future. As noted below and throughout this report there were a number of individuals with PNM-related concerns who would benefit from comprehensive assessment and supports with assessment by the newly established PNMT with oversight and review by the NMT. The incidence of some of these per documentation submitted was as follows: • <u>Pneumonia</u>**:** Per the list submitted, there were 30 occurrences for 21 individuals, with 12 identified as aspiration pneumonia. Thirteen of these individuals were enterally nourished, and eight with oral intake. Individual #511 had four incidents of aspiration pneumonia. Individual #397 had three incidences of pneumonia, one of those diagnosed as aspiration pneumonia. Four others had two incidents of pneumonia including Individual #390, Individual #216,	Noncompliance

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		Individual #59, and Individual #405. Each of the others had one incidence of pneumonia. This represents an 8% incidence for the current census of 416 and a 14% incidence given the current number of those identified with PNM needs (221). Individual #397, Individual #405 and Individual #390 were only reviewed by the NMT on one occasion. • Aspiration: Per a risk list that only addressed aspiration risk dated 8/17/10, there were four individuals identified at high risk for aspiration and included Individual #216, Individual #59, Individual #405 and Individual #212. There were approximately 23 individuals identified at medium risk. These numbers did not coincide with the list submitted and regarding risk levels for all areas described above which only identified Individual #212 at high risk for aspiration. It was of great concern to the monitoring team that MSSLC did not appear to recognize the importance of the identification of those at high risk for PNM concerns, such as aspiration. There were at least 32 individuals listed as receiving nutrition and hydration enterally and likely at risk for aspiration. There were 12 individuals who had been diagnosed with aspiration pneumonia. There were numerous individuals with a diagnosis of severe dysphagia. The designation of risk in this area appeared to be more driven by meeting frequency rather than actual risk or incidence. • Pressure ulcers**:** The following individuals had documented pressure ulcers: Stage I (Individual #544, Individual #251, Individual #359, Individual #28, Individual #389, and Individual #171); Stage II (Individual #480, Individual #405, Individual #239, Individual #544, Individual #256, Individual #390, Individual #331, Individual #28, Individual #475, Individual #11, Individual #281, Individual #322, Individual #130, Individual #134, Individual #470, Individual #491, Individual #417, Individual #521, Individual #520, and Individual #249); Unstageable (Individual #95, Individual #432, Individual #268); Deep Tissue Injury (DTI) (Individual #375). Each of these were listed as seated in wheelchairs for the primary means of mobility. • Choking**:** There were five individuals who experienced choking incidents: Individual #589, Individual #41, Individual #164, Individual #431, and Individual #14. Individual #41 died secondary to this event. In addition, there were two other individuals who had choking events during the month of this onsite review including Individual #196 and one other individual on the final day of the monitoring team's onsite visit. • Fecal Impaction**:** There were four individuals with a fecal impaction in the last 12 months. They included Individual #474, Individual #556, Individual #560, and Individual #513. • Osteoporosis**:** Information not submitted. It was of concern that this did not appear to be tracked by the facility.	

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		• Dysphagia: There was no list of individuals with a diagnosis of dysphagia, however, a number did receive modified diets and/or thickened liquids. There were approximately 62 individuals on a pureed diet. There were approximately 34 individuals on a ground diet. There were approximately 30 individuals on a chopped diet. There were approximately 32 to 35 individuals who received enteral nutrition (documentation varied). There were nine who received pudding thickened liquids, 21 individuals who received honey-thickened liquids, 11 who received nectar-thickened liquids; all others were either enterally nourished or received regular fluids. There were 25 individuals who received a downgrade to their food texture or fluid consistency. Six of these were NPO (nothing by mouth), including Individual #544, Individual #390, Individual #359, Individual #111, Individual #148, and Individual #438. • Falls**:** There were 65 individuals who had experienced a fall in the last 12 months. • Weight**:** There were 15 individuals with a Body Mass Index (BMI) of 20 or less, 11 of whom were under 18.5 indicating underweight status. Individual #359 had a 19.9% weight loss in six months secondary to hospitalization. There were 66 individuals with a BMI of 30 or greater indicating that they were obese. Six had a BMI greater than 40 indicating that they were morbidly obese. • Physical Challenges**:** Approximately 152 individuals used braces or other orthotics. There were 11 individuals who used assistive devices for ambulation. There were 83 individuals who used a wheelchair for their primary means of mobility and 40 individuals who used wheelchairs for transport only. • Hospitalizations**:** There were at least 30 individuals with PNM-related hospitalizations (discharge diagnoses) during 2010 to date. Four of them were deceased at the time of this review, including Individual #511, Individual #347, Individual #501, and Individual #397. The PNMP contained information related to the focus, hearing/vision, assistive equipment, communication, mobility, transfers, movement instructions, skin care, bathing and positioning as well as mealtime instructions. The plans identified an implementation date as well as an update. The dates of the plans were not consistently changed at the time of the annual PSP meeting to indicate that they had been reviewed at that time whether or not changes were required. As a result the implemented date did not assist staff to know which plan was most current as there were ongoing updates as indicated. Some examples with implementation dates in parentheses included Individual #301 (3/3/09), Individual #5 (5/14/09), Individual #503 (8/31/09), Individual #451 (2/17/09), Individual #134 (2/23/09), Individual #521 (5/11/09), and Individual #233 (5/4/09). A number of others were due to expire during the month of September 2010 and had not as yet been reviewed.	

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		Criteria used to develop a comprehensive individual record sample of 22 individuals at risk included: • Emergency Room visits • Hospitalizations • PNMP Committee meeting documentation • Individuals with active pressure ulcer within the last 6 months • Individuals with severe dysphagia • Individuals with chronic constipation or who experienced fecal impaction within the last six months • Individuals with unexplained weight loss or BMI ≤ 20 • Individuals ≥ BMI of 30 • Individuals who experienced a choking incident which required abdominal thrust within the last six months • Individuals with a diagnosis of aspiration pneumonia • Individuals who have experienced significant falls related to transfers and/or ambulation • Individuals with chronic respiratory infections • Individuals with chronic dehydration • Individuals with a diagnosis of osteoporosis and/or osteopenia • Individuals who experienced a fracture • Reviewer observations of mealtime, positioning, transfers, medication administration, tooth brushing, personal care and functional communication The PNMPs submitted for each of these individuals was reviewed with findings as follows: • 20 of 22 PNMPs reviewed were current within the last 12 months. Individual #212's plan expired 9/14/09; there was no plan submitted for Individual #347 and this individual was not included on either list regarding PNM needs. • In 21 of 21 of PNMPs reviewed (100%), mobility was addressed. There were four of 21 PNMPs reviewed (19%) that identified the individual as independent with mobility and as not requiring any assistive devices or physical assistance from staff. Others required a wheelchair for distances or were seated in a wheelchair as their primary means of mobility. • In 17 of the 17 PNMPs reviewed (100%) of individuals who used a wheelchair, specific positioning instructions for wheelchair and/or alternate positions instructions were included. • In 17 of 17 PNMPs reviewed (100%) of individuals who required transfer assistance, the type of transfer was included. Four individuals were identified as independent. • In 19 of 21 PNMPs reviewed (91%), the PNMP listed bathing instructions, though	

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		most were very limited. • In 16 of 20 PNMPs reviewed (77%) "Movement Instructions" were included. Four of the plans stated that this was not applicable to those individuals and this section was left blank for Individual #216. There were 13 individuals whose plans instructed handle with care due to fragile bones. Three others documented care to prevent a catheter from being pulled out, required QMRP notification of falls, or removing small objects due to risk of eating inedible objects. • In 10 of 21 PNMPs reviewed (48%), the mealtime instructions section did not include any information, but rather only referred staff to the Dining Plan. Three of the 21 individuals (15%) received all of their nutrition via gastrostomy tube and nothing by mouth, so oral intake instructions were not indicated though there was reference to a Dining Plan. The plan for Individual #431, however, addressed food texture, liquid consistency, and after-meal positioning. The plan for Individual #488 identified her liquid consistency and stated that she could sit on the side of her bed for meals. No other instructions were included for either individual, but rather the staff were referred to their Dining Plans. Four plans only indicated the liquid consistency and referred staff to the Dining Plan. One other merely indicated that he should eat separately from his peers (Individual #164). • In 1 of 21 PNMPs reviewed (5%), food texture was included. • In 6 of 21 PNMPs reviewed (29%), assistive mealtime equipment was included. It could not be determined if the others had equipment and it was omitted or that they did not require it. • In 1 of 21 PNMPs reviewed (5%), strategies for mealtime assistance were included, though pertained only to seating him separately from his peers (Individual #164). • In 0 of 21 PNMPs reviewed (0%), strategies for medication administration were included. • In 0 of 21 PNMPs reviewed (0%), strategies for oral hygiene were included. • In 1 of 21 PNMPs reviewed (5%), individual dining positioning was addressed in the plan. This was noted only for Individual #488 and stated only that she could sit on the edge of her bed for meals. • In 19 of 21 records reviewed (91%), some type of bathing instructions were included. Six identified specialized equipment. Three identified staff assistance from one or two staff. Nine others indicated that the individual should sit during bathing and/or wear earplugs. One merely stated that Basis soap should be used for Individual #488. A bathing table was also listed for her under assistive equipment, but there was no reference as to how it was used for bathing. • All the plans included a heading related to communication, though, in most cases, this only referred the staff to the Communication Dictionary for instructions	

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		(72%). One of these, for Individual #405, also referred to augmentative device instructions and listed a CD player with toggle switch as assistive equipment. In addition the individual was identified as responding to tactile stimuli. In all but one of these, the Communication Dictionary was listed as assistive equipment in the designated section. Two others were listed as verbal, but no additional information was included. Individual #41 was described as nonverbal but also that he used gestures, some signs, facial expressions, eye movements, vocalizations, pointing, and pulling to communicate. He also followed simple instructions. There was no reference to a Communication Dictionary, though he had one, dated 2/26/10. Individual #148's plan referred to his Communication Dictionary and Augmentative Device Instructions. The type of device was not identified, however, he had a lap tray to be used with the device. Individual #431's plan referred to her Communication Device and Augmentative Device Instructions and both of these were listed in the assistive equipment section. It further described her as nonverbal but used facial expressions, gestures and a few words that were difficult to understand. **Standard: PNM plans were incorporated into individual's Personal Support Plans.** Information from discipline specific assessments was included in the assessment portion of the PSP including OT/PT, Nutrition, Speech, Medical, and Nursing, among others. Findings and recommendations were generally listed there. In 77% of the PSPs reviewed there was also a section under the General Discussion Record that addressed review of the PNMP, however, in most cases, there was merely a statement that indicated that the PNMP was reviewed and that changes would be made as needed. There was no specific review of the elements of the plan, nor was there documentation of what changes were required. In the case of six individuals, there was no documentation regarding the PNMP or that it had been reviewed by the PST. These included Individual #347 (no PNMP was submitted for him), Individual #196, Individual #523, Individual #212, Individual #41, and Individual #435. The PSP and PNMP were consistent with regard to required assistive equipment for Individual #164, Individual #486, and Individual #405 only. In all other cases, there were discrepancies between the two documents that had not been addressed by a PSP Addendum. The following individuals had equipment listed in their PSP that was not included in the PNMP: Individual #41, Individual #59, Individual #148, Individual #411, Individual #35, and Individual #212. Individual #438 received enteral nutrition per a PSP addendum but his PNMP had not been updated to reflect this significant change in his status. The following individuals had equipment listed in their PNMP that was not included in	

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		their PSP: Individual #268, Individual #431, Individual #256, Individual #589, Individual #216, Individual #488, Individual #322, Individual #523, and Individual #435. As stated above, there was no PNMP submitted for Individual #347 though he appeared to have one, per additional documentation reviewed. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** Individuals who had received PNM supports were reviewed in the PNMT clinic prior to the annual PSP meeting to complete assessments/updates and to address changes needed in the PNMP. These findings were documented in the OT/PT and SLP assessment reports. Recommendations were listed in the assessment sections of the PSP. By report, further discussion and review were conducted during the PSP meeting with other team members though, as reported above, this was not well documented in the PSP. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.** In 16 of 21 PSPs reviewed, there was a section in the General Discussion Record of the PSP that included a PNMP heading. As described above, however, the review documentation was very limited.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	**Standard: Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.** Based on observations of individuals during meals across a variety of homes there continued to be concerns for staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP. Some examples are presented below: • Individual #35 was observed in an extremely unacceptable position in his wheelchair. His hips were forward to the very front of his seat bottom and his legs were hanging off the foot rests. He was held into the chair only by the seatbelt. He was observed crying, vocalizing and biting his hand though no staff attended to him. The nurse administering medications in the area was asked if he had been given his medications and she indicated that he had. When asked to address his position she said that "he wasn't slid down quite that far." She got assistance from other staff to reposition him. • Individual #281 was observed shoveling a lot of food in his mouth during a meal. He was also wearing a helmet, though his plan did not picture him wearing it. • Individual #88's glass was to be filled half full and this was not done. There was one staff at the table of four men each of whom required some level of	Noncompliance

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		supervision and/or physical assistance. All were drinking from paper cups. Staff reported that the paper cup contoured to his mouth better than a regular cup. • A direct support staff assisted Individual #144 by sitting behind him on a stool high above his head. The staff was rapidly presenting bites of food and did not look at him or interact with him with the exception of a couple of times when he looked around to the front of his face to wipe off his mouth. He presented three containers of tomato juice in rapid succession, allowing him to gulp the liquid. Instructions further stated that staff were to alternate food and fluid. All liquids were presented after the food. The Dining Plan indicated that all liquids were to be pudding thick except for tomato juice. When asked the staff were not able to give any justification for this modification. One staff replied, "I don't write the diet cards." • The Dining Plan for Individual #35 instructed staff to present food in "normal posture." It was not clear what that meant and staff working with him were not able to explain it. His food had sat in front of him for more than 15 minutes with no staff present to assist him. When staff returned, he refused. Staff tried to present three bites which he refused and the meal was ended. • Individual #256 was observed to be sneezing three to four times and then began to cough. The monitoring team pointed out to staff that he was to receive pureed and food and had been served ground meats. He was to have honey-thickened liquids and was offered chocolate milk that had not been thickened. Staff indicated that they had not yet presented any fluids, yet the Dining Plan had prescribed that they alternate bites of food with fluid. At any rate, the plan was not implemented as written. • Individual #126 was eating with no staff sitting with him. Staff joined him when the monitoring team was reviewing the plan. They could not provide rationale for why he was on a puree diet or was to use a straw. The finally stated, "I guess from the swallow study." • Individual #155's plan indicated that there were no precautions. Staff indicated that he was on a pureed diet to reduce his risk of choking. Individual #155 was observed gulping a full cup of liquid with staff supervision and no intervention. • Individual #349 was served large pieces of chicken, though his plan indicated that it should be chopped. • Individual #404 was observed to grab sugar packets from the table and put them in his mouth. A staff turned, observed this, and removed them from his mouth. He was noted to be on enhanced supervision due to a risk of eating inedible objects. He was to receive chopped foods, yet he was served food items that were larger than one half inch. • Individual #75 was to receive chopped foods with ground meats. The chicken he was served was cubed. Staff were directed to correct this.	

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		• Individual #147 was observed to be eating rapidly and staff did not provide prompts to slow down or to encourage him to alternate food with fluid, as per his Dining Plan. It was also noted that there were large chunks of fruit. His diet order was ground. Kitchen staff were asked to check the fruit and they discovered very large pieces in the fruit designated as ground. • Staff permitted Individual #102 to take large bites with a maroon "care" spoon. • Individual #196 was reviewed in the NMT meeting on 9/16/10. The SLP reported that she conducted a mealtime observation as a follow-up to a choking incident one week ago. She reported that she observed Individual #196 eating a "beautiful" ground diet meal (her diet order had been changed to ground per her report), but also reported that she did not chew well, continued to eat all of her food fast, and then drink her fluid. It was of concern that the SLP did not report that she intervened at that time. It was discussed that she was an "aggressive eater," was "strong willed," and that staff were too short to provide one-to-one supervision. It was recommended that her diet order be changed to ground. The monitoring team noted that her current dining plan continued to prescribe a chopped diet that she was receiving while observed to take large bites at a fast pace. It was of great concern that Individual #196 continued to be at great risk of choking a full week after this recent episode. • Individual #171 was observed leaning to the left in her wheelchair during her meal. Staff reported they were not able to keep her aligned and had reported this to Habilitation Therapies. • Individual #177 was seated alone. Her meal was sitting in front of her, covered for over 15 minutes. There were flies landing around her. Staff was promoted to get her a new tray as this one was cold. • Individual #128 was seated at the table with her tray in front of her with no staff assistance. • There were nine women reported to live in home M8. One individual received enteral nutrition and there were six in the dining room at one time. There were two individuals waiting for staff assistance. One was not eating, but required one-to-one supervision. Another woman was independent but required some assistance and was not eating (Individual #335). Two staff were assisting others. Eventually two staff began to assist the two individuals who were waiting with food in front of them. There was insufficient staff for these six individuals to eat in one shift. • Individual #335 was to receive a chopped diet. The bread served to her was in larger pieces. She was not provided any beverage. Though she ate and drank independently, she required prompting to use her spoon, take appropriate size bites and to pour one half to one inch of liquid in her cup at a time. There was no supervision at the meal observed and she was not eating at that time.	

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		• Individual #322 coughed numerous times, some of which were quite significant. He was being served pudding thick liquids that had been made with the new gel thickening agent, yet was much thinner than prescribed. The staff had been working hard to thicken the liquid appropriately, but had been unsuccessful. The staff was directed to discontinue the meal until a nurse checked him out. A nurse came to check his vitals and stated, "He is moving air." She did not identify any concerns. An RN was passing through the area and also checked Individual #322. She detected some wet breath sounds and assisted him to cough until they were cleared. She instructed staff to reposition him. The staff attempted to lift him with the tray and seat belt on. They pulled him up by his armpits. The PNMP and COTA were also present and intervened to correct this and Individual #322 was properly repositioned at that time. • Individual #4 was observed to be drinking from a bowl. His dining plan instructed that he should use a "care" spoon. This was extremely difficult for him and he expended much energy to do so. When asked about this, staff offered him a cup. Wheelchair positioning instructions were not specific in the PNMPs. Limited instructions identified that individuals should remain upright, described the angle of recline, and the type of transfer to be used. General practice guidelines with regard to transfers, seatbelt use, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation. Primary concerns for positioning and alignment were related to not positioning the pelvis back in the seat, posterior tilt of pelvis, and inadequate foot support. There was no precision with regard to position and alignment and staff did not appear to be as tuned into this particularly during mealtimes. Alternate positioning was not observed other than seating in a recliner. Medication administration and tooth brushing instructions were not included in the PNMP. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** Dining plans were generally out on the tables during the meals with the exception of one home. Staff reported that a number of individuals had moved there from the Longhorn unit and arrived without their plans. By report, these had been ordered weeks earlier. When they were not received, she had printed non-laminated copies from the computer for staff use (Individual #86, Individual #496, and Individual #158). Two others did not have a Dining Plan (Individual #252 and Individual #89). Staff were not able to provide the rationale for instructions included in the plans throughout many of the homes. It was of concern that homes were not able to obtain replacement Dining Plans in a timely	

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		manner. This placed individuals at risk if staff did not have access to key information provided in these plans.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	**Standard: Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.** Review of the Facility's training curricula revealed that with the exception of transfer training, much of it was knowledge-based training with little to no skills-based training. With the exception of transfer training, there were no skill competencies established. By report, there was a statewide effort to address this that was in the early stages only. A special training for the PNMP coordinators had been provided by Gary Sandler, OTR, on 8/16/10. The training roster cover sheet stated that the program title was "Transfer Training," but he content was described as "the basics of choking, risks for choking, and monitoring individuals and equipment as described in the dining plan." This training was provided to nine PNMPCs and the supervisor, Pam Harlan, COTA. In addition, "Oral Care" training was provided by Pam Harlan, COTA to eight PNMP Coordinators on 9/9/10. There was a statement that each participant demonstrated correct procedures for tooth brushing with an individual who received nothing by mouth or required thickened liquids. There was no evidence that either of these was competency-based via skill check-off documentation. **Standard: Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre-/post-test, which may also include return demonstration as applicable.** Training was not competency-based at this time. **Standard: All foundational trainings are updated annually**. Only lifting training was updated after initial NEO training, but only on an every two year basis at this time. **Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel.** Initial staff training was conducted by professional staff and PNMP Coordinators. PNMPCs provided routine ongoing coaching and re-training based on observation and monitoring conducted in their assigned homes. In addition, home supervisors also were responsible for direct support staff training, but none of it was competency-based. Based on Dining Plan training records submitted for seven individuals, training was limited to 15 minutes and in most cases only one or two staff were trained. There was no evidence that this	Noncompliance

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		training was competency-based. **Standard: PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual.** Staff training was not currently competency-based, so while staff may have received some level of training for implementation of PNMPs for those at high risk, it was not performance-based, and did not require successful performance of clearly established competencies. Training was not consistently effective as evidence by the numerous implementation errors noted by the monitoring team and described above. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.** See above.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	**Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.** There was no policy that related to the process of monitoring. **Standard: Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).** Monitoring was conducted to address mealtimes, as well as communication, transfers, and positioning in the homes. Bathing/showering and toileting equipment was reviewed for condition and cleanliness, and there was evidence of routine monitoring of transfers, positioning, and support in these. Mealtime monitoring conducted was noted on the mealtime observation forms. There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. A new form was implemented in August 2010 in an effort to combine the PNMP and mealtime monitoring process. The monitor was to mark the type of activity including meal, snack, bathing, medication administration or oral care. There had been a tremendous number of monitoring sheets completed in the last three months, predominately by the PNMP coordinators and some by Pam Harlan, COTA. There were no sheets completed by other professional staff noted. Approximately 212 individuals were monitored, many on multiple occasions. There was no method to track	Noncompliance

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		the frequency of observation conducted for specific individuals who were considered to be at highest risk, though a schedule had recently been developed. **Standard: All members of the PNM team conduct monitoring.** By report, the clinicians were to conduct monitoring of Dining Plans, one time a week in one home, the PNMPs and transfers one time a week in one home and the PNMP Coordinators one time a month for validation. There was no evidence of this noted however. Documentation submitted appeared to be completed only by the PNMPCs and their supervisor Pam Harlan, COTA. **Standard: Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team.** There was no mechanism to track data for system analysis in order to focus training and coaching. The NMT did not utilize PNMP monitoring information in their reviews. Meal observation information was used occasionally. The NMT did not specifically review aggregated findings across homes for trend analysis to drive system change and training. There was no system in place to conduct trend analysis to consistently review if interventions had a positive outcome on an individual's health status. They also did not review overall incidence of health concerns such as aspiration pneumonia, use of bowel management aides, weight loss/gain, falls, fractures, and so forth over time to address system outcomes as a result of interventions and supports. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** There was an expectation of immediate intervention when a individual was determined to be at risk of harm. When present during observations by the monitoring team, PNMP Coordinators and the PNMP supervisor, Pam Harlan, COTA were observed to intervene when the PNMP, particularly the dining plans, were not properly implemented by direct support staff. Home supervisors were not observed to intervene unless prompted to do so. There was no mechanism to track training related to, communication of, or follow-up to concerns noted during monitoring.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to	**Standard: A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.** The NMT assigned a nutritional risk level for each individual reviewed. The team did not appear to complete a specific screening tool for this but it appeared to be driven by the	Noncompliance

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	monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	identified need for follow-up intervals as described above. The HST screening was completed every six months. The PST was to meet monthly on those deemed to be at highest risk. The HST screening system also reviewed a variety of health risk concerns. These two systems were not integrated and were inconsistent. By report, both systems were being revised by the state and further review will be necessary in subsequent reviews by the monitoring team. **Standard: Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.** Unless an individual participated in direct therapy, there was no consistent interval of review of other supports for those individuals who presented with PNM health risk indicators by professional staff. In the case that an individual participated in direct therapy, a monthly progress note was written, but functional and measurable goals were not identified in all cases. There was no system of monitoring of PNMP effectiveness for those at highest risk. A statement was submitted in response to the document request that indicated that this was not done due to staffing shortages. Follow-up was based on referral and in those cases a consult report was completed. As described below, very few of these were noted, particularly in the last 12 months, in the personal records of the sample reviewed by the monitoring team.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**Standard: All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.** There were at least 32 individuals listed as receiving nutrition and hydration enterally. There was no evidence that there was a specific NMT review of those who received enteral nutrition on annual basis. The SLPs did include a discipline specific assessment as an aspect of their annual review of these individuals. A bed-side evaluation was completed as well as oral intake trials when deemed appropriate. These assessments, however, were conducted in isolation of other professional staff and, as such, should not be considered sufficient upon which to judge appropriateness of continued enteral intake or potential for oral intake. The following individuals included in the sample for review received enteral nutrition according to the list provided: • Individual #148, Individual #405, Individual #216, Individual #59, Individual #411, Individual #486, Individual #268, Individual #438, Individual #435 Another two individuals were documented as receiving enteral nutrition, but were not included on this list submitted (Individual #331 and Individual #523). Each of these 11	Noncompliance

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		individuals had PNMPs as follows: • Individual #148 (7/25/10) • Individual #405 (3/8/10 • Individual #216 (5/4/10) • Individual #59 (2/9/10) • Individual #411 (5/24/10) • Individual #486 (7/20/10) • Individual #268 (5/28/10 • Individual #438 (4/4/09) • Individual #435 (5/11/10) • Individual #331 (7/13/10) • Individual #523 (6/16/10) While they each had PNMPs ,only two of these actually identified that the individual received enteral nutrition (Individual #148 and Individual #523), however, a PSP Addendum dated 7/16/10 documented that he was to begin a pureed diet with honey-thickened liquids for all meals and snacks based on the Dysphagia Consult dated 7/12/10. The PNMP or Dining Plan submitted as current had not been revised to reflect this change. There was no review by the NMT noted in the meeting minutes regarding this significant change in status. Each of the PNMPs for the other individuals merely referred the staff to the Dining Plan "for all meals and snack instruction." This was of concern since these individuals did not likely receive oral intake and staff did not have this reference available to them in the PNMP to further ensure their safety. **Standard: People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.** All individuals who received non-oral intake had been provided a PNMP and dining plan that included the same elements described above. Specifics related to their intake, however, were not included in each of the PNMPs submitted and some inconsistencies were noted as described above. **The need for continued enteral nutrition is integrated into the PSP.** Based on a review of 21 PSPs in the individual record sample, there were 11 individuals who received enteral nutrition, though by report, Individual #148 had recently returned to oral intake. These individual's PSPs did not document the rationale for the continued need for enteral nutrition. **Standard: When it is determined that it is appropriate for an individual to return to**	

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		oral feeding, a plan is in place that addresses the process to be used. Though recommendations had been made for return to oral intake and approved by the PST for Individual #148, the PNMP or Dining Plan had not been appropriately updated to reflect this significant change in status. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** There were no facility policies that defined the frequency and depth of evaluations related to an individual receiving enteral nutrition. **Standard: Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.** The intent of the PNMP and dining plans was to provide consistent and effective supports to minimize the incidence of aspiration, oral intake to promote weight maintenance, and positioning and assistance techniques to ensure safe eating and drinking. Below is described a recent case. Individual #41 was deceased at the time of this onsite review secondary to choking. He had a long history of numerous choking episodes. There were four between April 1999 and May 2006 as well as others on 1/9/09 and 5/6/09. He also presented with pneumonia (3/25/09), aspiration pneumonia (3/31/09), and other respiratory concerns, also in 2009. He received a ground diet with regular liquids recommended in the dysphagia evaluation dated 1/21/09. Continued ground diet with nectar thick fluids was recommended on 2/25/09, secondary to flash penetration on thin liquids. Another MBSS was conducted on 5/8/09 due to pneumonia following a choking incident two days earlier. Recommendations were to continue the current diet of ground foods and nectar-thickened liquids. He had another choking incident on 9/9/09. On 3/18/10, he was identified at high risk of choking per the HST rating tool. He had a BSP for food stealing. Coughing and congestion were reported in the progress notes from 6/9/10 (previous notes not submitted) and were treated as an upper respiratory infection with Augmentin and Mucinex. Several falls with injury, and reports of coughing after meals were reported on 7/21/10. There was a request for the SLP to observe a meal on 7/21/10. A wet cough was noted after drinking nectar-thick liquids. The SLP presented a trial of honey-thick liquids with the recommendation to implement this change. Per nursing, the change was	

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		implemented, though with continued intermittent episodes of coughing after drinking fluids. A repeat MBSS was ordered. There was no documentation of follow-up by the SLP after the change in liquid consistency. There was a significant coughing event on 7/27/10 with subsequent reports of coughing through 8/3/10. On 8/13/10, nursing documented a possible choking event while eating a sandwich. Staff removed it with a finger sweep. The physician ordered an upgrade to a regular diet and continued honey-thick liquids with a provale cup subsequent to an MBSS on 8/9/10. The findings of this study were not documented in the progress notes or via a consult by the SLP. The MBSS Report was not submitted. There was no follow-up noted by the SLP to monitor these changes. The NMT reviewed these changes on 8/17/10 and recommended follow-up in one month. On 8/18/10, Individual #41's choking risk was reduced to medium. Per progress notes, the "diet card" had not been changed to reflect these changes, however. On 8/21/10, Individual #41 choked at a restaurant. He was intubated, hospitalized, and placed on a ventilator. He later died. At the time of the onsite tour, an investigation was being conducted by both DFPS and OIG. The investigation was near completion at the time of submission of this report and indicated that neglect was unconfirmed (DFPS) and that no criminal activity was substantiated (OIG).	

Recommendations:

1. Include PT staff in NMT meetings; consider closer collaboration with the Health Risk Screening process as well.
2. Ensure increased opportunities for annual continuing education opportunities to include all NMT team members.
3. Establish measurable outcomes related to occurrences of risk indicators or identified PNM concerns.
4. Utilize the monitoring system to fine-tune PNMPs and dining plans for consistency and accuracy and to ensure improved staff compliance with proper implementation. Trend analysis of monitoring should be utilized to better target staff training.
5. Revise current new employee training to ensure that it addresses skills-based competencies rather than only knowledge-based learning objectives. Competency check-offs should include an activity analysis, highlighting the skills necessary to complete the task. Staff should be expected to perform each skill to criteria to achieve competency. Create annual refresher courses with competency-based check-offs to ensure continued competence.
6. All individual-specific training must be competency-based and documented with staff sign-in sheets. Design checklists to use to rate staff performance with key skills related to implementation of support plans for individuals with PNM needs. Only staff who have been checked off

should work with those at highest risk.

7. Ensure that the monitoring system is based on individual-specific needs; those at higher risk should be monitored with greater frequency. Include a mechanism to document recommendations for follow-up and a means to document closure on issues identified. This often works well when this is included on the form used to monitor.

8. Ensure that re-validation of monitors occurs on a regular basis to ensure consistency and accuracy.

9. Conduct trend analysis of all monitoring data. Review findings and make system adjustments. Consider review of trends as a role for the NMT.

10. NMT review should focus on PNM concerns with follow-up through to problem resolution. Set outcome measures with regard to specific risk indicators and timeframes for achievement. For example, Mary will be pneumonia free for six months. Interventions should support achievement of identified outcomes. NMT should continue to monitor until the individual attains and maintains at the goal level. This may become more easily integrated with the new PNMT process.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** **<u>Documents Reviewed</u>:** o List of PNMT members o Continuing education documentation for OTs and PTs o CV for Gary Sandler, MOT, OTR, Interim Habilitation Therapies o Occupational/Physical Therapy Services #014P, 11/04/09 o OT/PT Evaluation-Baseline template o Completed PNM Monitoring Sheets submitted o QA monitoring forms for Section P, June/July/August 2010 o List of individuals with PNMPs o PNMPs (approximately 223 submitted) o PNM Clinic Summaries submitted o Walking Program/Physical Therapy April 2010 to Present o Ambulation Assistive Devices August 2010 o Wheelchair Data Spreadsheet 8/17/10 o Wheelchair Work Orders Modifications 9/10 o Individuals with Wheelchairs Used for Primary Mobility o Individuals with Wheelchairs for Transport 8/17/10 o Habilitation Therapy Services Database, orthotics 8/6/10 o Habilitation Therapy Services Database 5/5/10 o Alpha Client List with admission dates (8/24/10) o List of individuals receiving direct OT and PT o PT Progress Records for: • Individual #188, Individual #222, Individual #349, Individual #242, Individual #95, and Individual #467 o OT Progress Records for Individual #553, and Individual #171 o OT/PT Evaluations for the following: • Individual #553, Individual #203, Individual #408, Individual #297, Individual #1, Individual #265, Individual #294, Individual #449, Individual #257, Individual #272, Individual #336, Individual #240, Individual #433, Individual #392, and Individual #182 o PSPs and Addendums for the following: • Individual #553, Individual #203, Individual #408, Individual #297, Individual #1, Individual #265, Individual #294, Individual #449, Individual #257, Individual #272, Individual #336, Individual #240, Individual #433, Individual #392, and Individual #182 o New Employee Orientation training curriculum o Personal Record documents including: Personal Support Plans and Addendums, Integrated

Progress Notes (previous three months), Physicians Annual Medical reviews, Active Problem list, Significant Past Medical History, HST Assessment Tools, Comprehensive Nursing Assessment, Quarter Nursing Quarterly Assessments for the last PSP year, Habilitation Therapies section, PNM Monitoring for the last six months year, Mealtime Monitoring for the last six months, Communication monitoring forms for last six months for:

- Individual #35, Individual #256, Individual #488, Individual #196, Individual #322, Individual #41, Individual #216, Individual #438, Individual #148, Individual #435, Individual #411, Individual #347 Individual #523, Individual #405, Individual #268, Individual #164, Individual #431, Individual #589, Individual #59, Individual #486, Individual #331, and Individual #212

Interviews and Meetings Held:

- Gary Sandler, MOT, OTR/L, Interim Habilitation Therapies Director
- Doris Ricketts, OTR, MBA
- Lisa Finley, COTA/L
- Pam Harlan, COTA/L
- Sandra Opersteny, PT, MEd
- Sandy Leggett, PT
- Betty Cotton, PTA
- Cynthia Buchmeyer, PTA
- Robert Morgan, ATP
- Various Direct Support Staff in homes and day program areas

Observations Conducted:

- Living areas
- Dining rooms
- Day programs
- Habilitation Therapies clinic areas
- PNMT assessment
- PNMP Clinic
- Wheelchair Clinic

Facility Self-Assessment:

MSSLC's self-assessment identified noncompliance for all items in this provision. Per the POI reviewed, issues cited included staff vacancies that essentially were driving how needs were met. It was stated that concerns were prioritized as a result. Staff training was not completed due to staff shortage. Monitoring was sporadic. Assessments were not always completed in a timely manner and they lacked sufficient rationale for recommendations. Plans did not always have measureable outcomes and were not reviewed on a consistent basis. In many other areas, the department was "working towards implementation."

	This self-assessment was generally consistent with the monitoring team's assessment. It is recommended, however, that the self-assessment be broken down into smaller action steps for ease of implementation but also as a way to measure forward progress in smaller increments of success.
	Summary of Monitor's Assessment: The previous department director had taken a position as the Director of Quality Assurance and an Interim Habilitation Therapies Director, Gary Sandler, MOT, OTR/L was temporarily assigned to this role from another SSLC. His last day at MSSLC was 9/16/10 during the week of this onsite review by the monitoring team and he was returning to his full-time position as Director at Richmond SSLC. During the week of the onsite review, Sandra Opersteny, PT, MEd had been appointed as the subsequent Interim Director. There had been a 67% staff reduction for OT secondary to resignations at the time of this review. Per Mr. Sandler, the OT/PT clinicians had been reorganized during his tenure there to better meet the needs, yet there continued to be an ongoing shift in leadership and reduction in staffing that significantly impacted the effective operation of the department. There had been a recent collaboration with a vendor who held RESNA certification as an Assistive Technology Professional. This certification was not held by any of the MSSLC therapy staff. The addition of this professional was an excellent step in the improvement of assistive technology at the facility, particularly related to wheelchair seating and mobility. This had been met with significant resistance by the clinicians, however and, the success of this arrangement stood in the balance. The reorganization of the PNMP Coordinators appeared to have been a positive step and Pam Harlan, COTA, appeared to be a capable and competent leader for this very important group of staff. The current system of PNMP monitoring was generally limited to availability and condition, rather than function and fit. By report, however, the therapists were supposed to initiate PNMP and mealtime monitoring and documentation for those individuals who were deemed to be at highest physical and nutritional risk on a weekly basis and to provide validation of monitoring by the PNMPCs. Tracking and documentation of monitoring were not yet in place. PNMPCs, however, were more consistently providing staff training when issues and concerns were identified, both on the spot and with inservices. This was the primary area of improvement noted related to provision P. Assessment format, detail, and clinical reasoning varied greatly from report to report. Most of these were not comprehensive in that they contained some critical information regarding health risk indicators and, generally, only a list of medical diagnoses was offered with no real discussion of the individual' s medical history. Content with regard to review of supports and services provided over the previous year, and rationale for the provision of those supports, including assistive equipment, was sketchy and not consistently provided. PSP Addendums were generally not conducted to justify the addition of therapy services. Treatment plans were outlined in an acute care assessment, but were not included as training objectives in the PSP. These interventions were treated more like hospital or outpatient treatments rather than as an integrated aspect

	of the annual plan for an individual living in an SSLC. In most cases the goals were only marginally measurable.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	**Standard: The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.** The previous department director had taken a position as the Director of Quality Assurance and an Interim Habilitation Therapies Director was temporarily assigned to this role from Richmond SSLC. Gary Sandler, MOT, OTR/L was the Habilitation Therapies Director at Richmond SSLC since February 2008 and had functioned in this role at MSSLC for several months. His last day at MSSLC was 9/16/10, during the week of this onsite review and he was returning to his full-time position as Director at Richmond SSLC at that time. The Director's position had been posted, but with no applicants. During the week of the onsite review, Sandra Opersteny, PT, M.Ed., had been appointed as the subsequent Interim Director. It was reported on the last day of the onsite visit that MSSLC had received the first applicant for this position. No evidence of professional license or credentials was submitted for any of the OT/PT staff including the Interim Directors. Per Mr. Sandler, the OT/PT clinicians had been reorganized during his tenure there to better meet the needs, yet there continued to be an ongoing shift in leadership and reduction in staffing that significantly impacted the effective operation of the department. OT services were previously provided by two full-time occupational therapists. One of the COTAs had served as chairperson for the Nutritional Management Team (NMT). Another OTR and COTA had served as supervisors of the newly assigned PNMT Coordinators. The clinicians were reorganized as follows: three full-time OTRs provided clinical services, one of these recently assigned to serve as NMT chairperson (Doris Ricketts, OTR, MBA), two full-time COTAs provided clinical services with one of these assisting the chairperson of the NMT (Lisa Finley, COTA/L), and one COTA supervised the PNMP Coordinators (Pam Harlan, COTA/L). Previously, one additional COTA assisted with the wheelchair shop, though it was reported that there were three COTAs, so it was not clear if that staff member was still employed. There was no OT technician available. In June 2010, one of these full-time OTRs had resigned and a second OTR had turned in her resignation effective on 9/17/10. At the time of this review, only Doris Ricketts, MBA, OTR, continued to provide OT services. There had been a 67% staff reduction for OT secondary to resignation at the time of this review. By report, the state was investigating filling the current vacancies using a contract agency.	Noncompliance

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		Given the census of 416 at the time of this review, the caseload for the current configuration of OT staff was 416 for the single OTR (Doris Ricketts, MBA**,** OTR/L) because she was the only professional licensed to provide assessment and to design intervention plans. The OTR was also responsible to provide direct supervision of the three COTAs. There were only two COTAs providing direct and/or indirect OT for the entire facility. The third was responsible for supervising the PNMP Coordinators. Clearly, this was not acceptable coverage. PT services were provided by two physical therapists, one working full-time (Sandra Opersteny, PT, M.Ed.) and the other working 32 hours per week (Sandy Leggett, PT). Given the census of 416 at the time of this review, the caseload for the current configuration of PT staff was approximately 250 individuals for the full-time PT and 166.5 individuals for the part-time PT. Previously, there was an additional contract PT that provided services eight to 10 hours a week. While he was listed in the documentation submitted, he was not named during the interviews with staff, so it was not known if he continued to provide services at MSLLC. There were two PTAs (Betty Cotton, PTA, and Cynthia Buchmeyer, PTA). There was one PT technician. Fabrication of seating systems occurred onsite. Fabricators were responsible for collaborating with therapy clinicians to design seating systems for individuals living at MSSLC, fabricating custom components, and completing repairs and modifications. At the time of this review, there was one full-time fabricator foreman and two technicians. One of the technicians had been scheduled to retire in February 2010 per the baseline review and had not yet been replaced. By report, the facility was in the process of hiring a third technician in this role as well. There had also been a recent collaboration with a vendor who held RESNA certification as an Assistive Technology Professional. This certification was not held by any of the MSSLC therapy staff. The addition of this professional was an excellent step in the improvement of assistive technology at the facility, particularly related to wheelchair seating and mobility. This had been met with significant resistance by the clinicians, however, and the success of this arrangement stood in the balance. The PNMP Coordinators were assigned to specific homes. These positions were integrated back into the Habilitation Therapies department and conducted monitoring of PNMPs, provided staff training, and attended PSP meetings. They were supervised by Pam Harlan, COTA/L. Actual verification of continuing education was not submitted, though lists of continuing education attended since the baseline review was submitted as follows: Karen Fleming, COTA (14.5 hours, 20.5 in last 12 months) • Wheelchair and Bed Position	

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		• Rotator Cuff Syndrome • PNMP and Wheelchair Clinic Conference Lisa Finley, COTA (3 hours, 17.25 in last 12 months) • Dysphagia for Developmentally Delayed Individuals Victoria Lee, COTA (0 hours, 13.5 in last 12 months) Doris Ricketts, MBA, OTR (0 hours, 7.5 in last 12 months) • No hours since previous review Betty Cotton, PTA (1 hour, 2 in last 12 months) • Physical and Nutritional Management and Wheelchair Clinic Teleconference Cynthia Buchmeyer, PTA (.30 CEUs, 1.5 CEUs in last 12 months) • PNMP and Wheelchair Clinic Teleconference (3) Sandra Opersteny, PT (0 hours designated) • Wheelchair and Bed Positioning for the Geriatric Patient **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** Actual OT/PT assessments were completed rather than screenings. The monitoring team had requested five assessments completed by each therapist with the associated PSP to be submitted. As the OTs and PTs complete an integrated assessment and report, the documents submitted included Occupational Therapy/Physical Therapy Baseline Evaluations. These included the following: • Individual #449 (6/25/10 and PSP: 7/13/10)) • Individual #433 (6/18/10 and PSP: 7/6/10) • Individual #100 (6/28/10 and PSP: 7/19/10) • Individual #257 (6/8/10 and PSP: 7/1/10) • Individual #1 (7/20/10 and PSP: 7/14/10) • Individual #240 (7/26/10 and PSP: 7/15/10) • Individual #265 (7/19/10 and PSP:7/29/10) • Individual #294 (8/17/10 and PSP: not available, though held on 8/17/10) • Individual #49 (two of six pages only submitted and PSP: 7/22/10) Additional OT/PT assessments and PSPs were submitted as requested for the personal record samples for 22 individuals including: • Individual #35 (2/25/09 and PSP: 3/8/10) • Individual #256 (2/1/05, 10/23/09 and PSP: 12/15/09) • Individual #488 (3/26/10 and PSP: 4/19/10) • Individual #196 (9/1/09, 8/17/10 and PSP: 9/16/09) • Individual #322 (3/2/10 and PSP: 3/9/10) • Individual #41 (8/12/09 and PSP: 10/5/09)	

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		• Individual #216 (2/23/09 and PSP: 3/15/10) • Individual #438 (12/10/08, 10/5/09 and PSP: 12/1/09) • Individual #148 (4/9/10 and PSP: 4/19/10) • Individual #435 (10/8/08, 9/17/09 and PSP: 11/17/09) • Individual #411 (12/19/08, 9/17/09 and PSP: 1/7/10) • Individual #347 (6/14/04, 5/12/06, 5/4/09, 4/23/08, 3/10/09 and PSP: 5/13/09) • Individual #523 (10/13/09 and PSP: 11/2/09) • Individual #405 (2/19/10 and PSP: 3/3/10) • Individual #268 (1/11/10 and PSP: 1/14/10) • Individual #164 (2/23/09, 3/10/10 and PSP: 3/22/10) • Individual #431 (PSP: 4/20/10) • Individual #589 (5/28/96 – OT, 5/29/96 - PT, 12/19/06, 12/13/07, 1/9/09, 11/6/09 and PSP: 12/8/09) • Individual #212 (7/13/09 and PSP: 9/9/09) • Individual #59 (5/4/90, 1/15/10 and PSP: 2/24/10) • Individual #486 (7/2/10 and PSP: 7/20/10) • Individual #331 (2/28/05, 11/9/09 and PSP: 1/6/10) Of those assessments that were current within the last 12 months, there were nine that were baseline evaluations and another nine that were updates. Four others were updates, but not current within the last 12 months (Individual #212, Individual #216, Individual #347, and Individual #41). Individual #216 had not received an OT/PT assessment since 2/23/09 and Individual #347 had not received one since 3/10/09. None of the updates referenced a previous baseline assessment though seven of the records with a current update also contained a baseline OT/PT assessment. Some of these had been completed some time ago, however. For example: • Individual #331 had an update on 11/9/09, but his baseline had been completed over five years ago on 2/28/05. • Individual #59 had an update on 1/15/10, but his baseline evaluation had been completed over 20 years ago on 5/4/90. • Individual #589 had an update on 11/6/09, but her baseline was completed over 10 years ago on 5/29/96. She had three additional updates in the last four years. • Individual #256 had an update on 10/23/09, but his baseline had been over five years ago on 2/1/05. Only three individuals had recent baseline evaluations with subsequent updates and included Individual #411, Individual #435, and Individual #438. The personal records did not consistently contain the most current assessment and, in some cases, expired and	

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		likely unnecessary documentation had not been purged. Additionally, the OT/PT assessments for a sample of individuals admitted to MSLLC in the last 12 months was requested. Most appeared to have been completed with 30 days of admission as required. The format of the baseline assessment for Individual #297 was different than the others and appeared to be a draft. It was of concern that the report had not been finalized over one month later at the time of the onsite review and certainly well outside the 30-day requirement. Baseline assessments were submitted for the following individuals: Individual #203, Individual #392, Individual #408, Individual #336, Individual #294, Individual #328, Individual #182, Individual #297, Individual #240, Individual #100, Individual #257, Individual #1, and Individual #265. There were at least 18 of the 37 assessments reviewed (49%) that described individuals with movement disorders, and limitations in self-care and/or functional skills. There were 221 individuals identified with PNM needs by the department, however, it was noted that only six individuals received direct physical therapy treatment with many focused on interventions, such as range of motion rather than other more functional skills. A list submitted indicated that there were others who received direct PT but documentation was submitted for only six. Documentation was submitted for one individual who received direct OT services. Many others received only indirect supports via annual assessments, PNMPs, or dining plans. There were a variety of other assessments/screenings submitted, though only a few had been completed in the last two years and appeared to no longer be reflective of current delivery of supports and services. These included: • Occupational Therapy Consultation Summary Report (13 for four individuals, dated 1992-2009) • Occupational Therapy Evaluation Update regarding "soft hand grip/splint baseline" for Individual #268 dated 1/13/06 and for Individual #256 dated 3/31/05 • Physical Therapy Consultation Summary Report (six for five individuals, dated 1998-2010) • Functional Eating Skills evaluations (13 for eight individuals, dated 1990-2008) • Adaptive Equipment Center Consultation Summary Report (seven for six individuals, dated 2007-2010) • Wheelchair Evaluation Baseline (five for five individuals, dated 2006-2008) • Wheelchair Evaluation Update (four for four individuals, dated 2007-2008) • Wheelchair Evaluation for Individual #148 dated 7/11/00 • Occupational Therapy Evaluation regarding tooth brushing for Individual #331 dated 6/4/96	

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		There was no data system used to track completion of assessments submitted. As stated above, it appeared that while some had previously received OT and/or PT assessments, many had not received a recent comprehensive baseline assessment. Other than the actual assessments submitted, it was not possible to verify reports that all individuals had received a comprehensive baseline assessment. **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** On the list submitted in response to the monitoring team's request, there were 73 individuals listed for PT, though 36 were identified as participating in walking clinic and another three who were identified as participating in transfer clinic. Others were listed with a focus on transfers, flexibility of lower extremities, contracture management via braces, and ambulation with and without assistive equipment. There were 15 individuals who were listed for OT with a focus on contracture management via orthotics (and, in one case, use of a bed positioner), or range of motion of the upper extremities. One individual received OT to address fine motor skills (Individual #448). The monitoring team also requested the current OT/PT assessments, intervention plans, and progress notes for the last six months for all individuals who were listed as receiving direct physical and/or occupational therapy. In response to this request, a list of participants in Walking Program/Physical Therapy, April 2010 to present, was submitted with 23 names. Progress notes and recertification assessments, however, were submitted for only six individuals for physical therapy (Individual #95, Individual #222, Individual #188, Individual #242, and Individual #349) and for only one individual for occupational therapy (Individual #171). No annual OT/PT assessments were submitted for these individuals as requested. During the staff interview portion of this review, clinicians stated that PT provided direct services to five individuals and 15 participated in the walking clinic, and OT provided direct services to one individual post-CVA which was inconsistent with the undated documentation submitted as well as the progress notes submitted. It was of concern that there were such significant discrepancies in documentation regarding who received direct services. **Standard: If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status.** Many individuals living at MSSLC received some level of direct and/or indirect OT/PT supports and services. For example, each individual had a PNMP and a dining plan. It was not possible to determine if the all individuals who received annual updates had	

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		previously received a comprehensive baseline assessment that was being updated. If that was the case, the comprehensive assessment was not maintained in the record. As stated above, not everyone had a current assessment in his or her personal record. Current assessments were noted for eight of 11 individuals who received some level of service from OT and/or PT and were included in the sample of records requested by the monitoring team. Assessments for Individual #35 and Individual #347 were not current within the last 12 months based on the personal record documentation requested and received. There was no assessment submitted for Individual #431. There was one individual included in the sample who was identified as receiving OT and there was a current assessment noted for him (Individual #405). As described above, there was an alternate list submitted identifying individuals who received direct therapy. No assessments were submitted as requested for Individual #171, Individual #95, Individual #222, Individual #188, Individual #242, Individual #467, and Individual #349. There did not appear to be any discernible difference in content between the Habilitation Therapies Update and the Baseline Evaluation. The assessments were still clearly more focused on impairments and traditional clinical data rather than function and potential for skill acquisition. In many cases, the data reported did not significantly relate to the supports and services outlined, but appeared to rather be a rote exercise with minimal actual assessment and problem-solving. This was also noted in the assessment observed by the monitoring team. Assessment format, detail, and clinical reasoning also varied greatly from report to report. Most of these were not comprehensive in that they lacked information regarding health risk indicators and generally only a list of medical diagnoses was offered with no real discussion of the individual' s medical history. There was reference to the individual's current PNMP and the effectiveness of that plan. There was no identification of whether changes in the PNMP were required and no clinical analysis with rationale provided as a foundation for the recommendations identified. Specific risk indicators were not listed. There was no correlation with the health risk indicators identified by the NMC, HST, and/or interventions recommended by the clinicians. Content with regard to review of supports and services provided over the previous year, and rationale for the provision of those supports, including assistive equipment, was sparse and not consistently provided. In many cases, there was insufficient baseline outlined in the assessment to use for assessing progress as a result of intervention. The format for the baseline and update evaluations were very similar and would be difficult to discern were it not for the title because there was generally no specific reference to a baseline evaluation with date. As a result, the updates contained a significant amount of information and did not appear to update the reader as to the individual's current status relative to the previous status at	

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		the time of the baseline assessment and, as such, served essentially as another baseline. Though, as stated above, these were not generally comprehensive. It did not appear that any modifications to the assessment process had been made in the last six months. Extremely large numbers of recommendations were outlined in each assessment report and it was difficult to track each back as to why each one was important. Most reports organized them according to subject; those related to transfers were listed together under a heading and those related to the dining plan were listed together under that heading, for example. There was significant repetition of information throughout each of the reports. Per the Health Care Guidelines, the comprehensive assessment should address the following: • Movement; • Mobility; • Range of motion; • Independence; and • Functional Status across each of these areas (Health Care Guidelines, VIII.B.2) Range of motion was generally addressed, though in some cases it was limited to lower extremity only. Even when movement skills were included, it was rarely offered in a functional way, but identified general skills only. A few examples from the assessments are presented below. • Individual #486 had a baseline assessment dated 7/2/10. The report stated, "A new Occupational Therapy Baseline was completed on 5/27/10." The report was stamped as received on 7/29/10. A series of clinical data were reported. It was stated that she did not have static or dynamic sitting balance, but that she also had some control in sitting. There was no indication as to what that was and how it was reconciled with the fact that she had no sitting balance. It was reported that she participated in PT programming during the last year, but there was no mention of what that involved and how effective it was on her level of function or health status. This assessment did mention the PNMP and stated that the focus was appropriate, but did not state what it entailed. It was further reported that "therapeutic modification" and inservice was required, but did not state what was needed and why. There were 25 recommendations listed. This report was signed by two PTs and one OTR. • Individual #405 had a baseline assessment dated 2/19/10 that indicated a home assessment was conducted on 2/1/10. The report was stamped as received on 4/12/10, nearly two months later. Only lower extremity range of motion was addressed. Sensory or sensorimotor function, respiratory function, and	

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		behavioral considerations were not included. Other than shoulder elevation and rounding, there was no mention that he even had upper extremities, let alone any mention of function. There was no reference to his PNMP until the recommendations section. Recommendations stated that he should "continue with the bilateral splints during waking hours," but there had been no mention of the splints in the assessment and why he had them. There were 28 recommendations listed. This assessment was signed by two PTs, two OTRs, and two COTAs. • Individual #35 had a baseline assessment on 2/25/10. Only diagnoses were listed with no medical history described. Individual #35's lower extremity range of motion was reported. It was stated that his posture was evaluated in unsupported sitting, yet it was later reported that his static and dynamic sitting balance was poor. There was no mention of his upper extremities or his functional use of them. It was reported that he propelled his wheelchair with his right hand, but that it was not functional. There was no mention of how he ate in the functional eating skills section of the report, only that his dining plan, food texture, and equipment were appropriate. It was not until the assessment section that it was mentioned that he had functional eating skills that included scooping. It was documented that he had received a wound care assessment on 4/2/09 and stated that he needed a barrier cream on his buttocks with Duoderm for a Stage II pressure wound. It was not identified who did this assessment and if there had been any PT intervention, supports, or monitoring of the wound through resolution, but rather stated that the wound care nurse monitored. It further stated that he had been assessed for bilateral knee extension range of motion and was in therapy at the time of the assessment. There was no report of the baseline at that time and the effectiveness of direct therapy on this concern. There was no reference to his PNMP until the recommendations section. The report was incomplete (four pages only and no signature page). There were 21 recommendations on the pages submitted. • Individual #322 had a baseline assessment dated 3/2/10 that reported the evaluation had been conducted over a month before on 1/11/10 and 1/13/10. Only medical diagnoses were listed with no medical history outlined. There was no reference to his upper extremity status or function. His functional eating skills were not described in any way. Rather, it was stated that his utensil, sitting posture, chewing skills, and drinking skills remained the same. Since this was a baseline assessment, it provided absolutely no information regarding Individual #322's abilities. In the assessment section of the evaluation, it was described that he had showed some regression related to transfers, yet had participated in the walking and transfer clinic. There was no rationale as to why he had experienced decline despite receiving intervention. Again, this was not previously reported in the body of the report. The assessment section further	

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		stated that he needed to continue with the Physical Therapy Walking Clinic, but did not mention continuing the transfer clinic despite regression. The recommendations stated that "no physical therapy treatment was needed" and there was no recommendation related to continued participation in either of these clinics. Mobility recommendations indicated that he should walk in his home twice in the morning and twice in the afternoon with a gait belt, helmet, and hands on assistance of two staff. There was no frequency or duration information identified and no expected functional outcome or goal. **Standard: Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral.** It did not appear that therapists proactively completed follow-ups when there was change in health status or after an incident such as a fall. For example: • Individual #41 fell outside on 6/22/10, reportedly tripping on uneven pavement. He had an abrasion on his head per progress notes. There was no evidence of follow-up by PT. • Individual #488 experienced a fall on 7/16/10 with one-to-one staff holding the gait belt. She hit her mouth and bit her tongue. Per documentation, there had been an increase in agitation, falls, and injuries. There was a previously documented fall on 7/4/10 as well. There was no evidence of follow-up by PT. • Individual #523 was hospitalized from 7/21/10 to 8/2/10 for ischemic bowel and right hemicolectomy and again on 8/3/10 for sepsis from E. coli and candida, and acute hypoxic respiratory failure. Progress notes documented pneumonia and persistent vomiting. There was further documentation of "swallowed Sprite" reported and subsequent respiratory concerns. There was no evidence of follow-up by OT or PT regarding these changes in his health status. • Individual #411 was reported to fall and hit his head on the floor during a transfer on 7/13/10. There was no evidence of follow-up by OT or PT regarding this incident. • Individual #148 was recommended for return to oral intake following a MBSS on 7/12/10. There was no evidence of an OT/PT assessment related to position or adaptive equipment prior to this change or follow-up after he began oral intake. Per the POI, compliance was listed as "no," but it was commented that assessments were completed upon referral or change in status. It appeared that it was more likely that the assessment was completed if there was a referral, but there was no consistent method of completing assessments for change in status unless a referral was received.	

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		Standard: Findings of comprehensive assessment drive the need for further assessment such a wheelchair/ seating assessment. Most of the assessments described the seating system, limited rationale for the properties, and a statement of the fit and function. The clarity and thoroughness of these varied greatly from report to report. A mat evaluation and, in many cases, review of the wheelchair was an aspect of each annual assessment. In many cases, simple repairs or modifications were possible at the time of the review and, in the case that more extensive work was required, this was scheduled for completion at a different time. This may become more of a standard approach as the PNMT assessments are implemented over the next year. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** There was essentially no review of medical issues and health risk indicators, but rather a listing of the medical diagnoses only. In some cases, issues related to wound care or consults from the orthotist were briefly mentioned. Other consults, surgeries, hospitalizations, or other significant health concerns were not discussed in the OT/PT evaluations. Usually in the Nutritional Management section of the report, there was a statement of risk indicators that resulted in follow-up by the NMT, but did not review the history or status related to these. There was no link to the HST risk assessment. There was also limited reference to these with discussion of rationale for interventions recommended. Occasionally, a reference to current medications was noted. This should become more of a standard as the PNMT assessments are implemented over the next year. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** Each of the current assessments was signed by both the OT and PT and, in many cases, multiple clinicians of both disciplines signed. By report, there was an increased participation by the SLP in some cases when swallowing concerns or issues related to AAC were of note, and when input was indicated for review of the individual's seating system. There was no evidence of this, however, in the OT/PT reports submitted.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall	**Standard: Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has been developed as part of the PSP.**	Noncompliance

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	develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	PSP Addendums were generally not conducted to justify the addition of therapy services. Treatment plans were outlined in an acute care assessment, but were not included as training objectives in the PSP, even when the intervention occurred over an extended period. These interventions were treated more like hospital or outpatient treatments rather than as an integrated aspect of the annual plan for an individual living in an SSLC. In most cases the PT goals were marginally measurable, for example: • "walk for a distance of 1000 feet" • "walk for 1000 feet without any device" An appropriate objective is a clear description of expectations for the individual. When written in behavioral terms, an objective should include three components: the anticipated behavior, conditions of performance, and performance criteria. These goals had no performance parameters or conditions including level of independence or assistance expected, such as "with stand-by guard of one person" or "per goniometer measurements in sidelying." There were also no performance criteria outlined, such as the frequency or duration of the expected behavior (e.g., "three of five times for three consecutive days"), or whether it was acceptable for the behavior to occur one time only. In other cases, the goals were limited to "sitting balance considered good," or "walk independently," neither of which would be considered to be measurable. Additional goals were related to the attainment of a certain range of motion measurement, such as "hip extension bilaterally of 0˚." Range of motion goals or other impairment level problems, such as muscle weakness, for example, in and of themselves would not be representative of functional gains and would not generally be reimbursable in the community and, as such, should not be considered acceptable in the SSLC setting. For example, Individual #188 had received physical therapy related to range of motion for hip and knee extension bilaterally from at least 3/8/10 through 8/25/10 per the documentation submitted. The assessment did not identify the functional limitations that were evident for Individual #188 that necessitated PT four to five times a week for six months. Individual #188 had only gained 10˚ of hip extension on the left and 5˚ of hip extension in six months' time. She had gained only 5˚ of knee extension bilaterally in six months' time. Six months of therapy to gain 10 to 20 degrees of movement was not acceptable. Individual #222 had received direct PT five times a week for range of motion exercises following a right distal femur fracture during bathing. From 4/16/10 through the most current acute care assessment by PT, it was documented that she had gained only 10˚ of knee extension on the right in nearly four months. Hip extension remained the same bilaterally, and knee extension on the left remained within normal limits. In both of these cases, there was no description in the acute care assessments as to how, and if, these limitations impacted their functional performance.	

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		The functional outcome should be the goal, not merely a change at the impairment level. This is not to say that these individuals did not need, or would not benefit from, continued PT, but it should be linked to a functional outcome for both of them. Additionally, there was a significant amount of direct PT resources directed to them for what appeared to be minimal functional improvement and, as such, this then limited allocation of these resources to other, likely more functional purposes for a wider range of individuals and their staff. There were no therapeutic goals identified in the documentation submitted for Individual #171 in seven or eight months of direct OT services following a stroke. There were no acute care assessments submitted throughout this period, as was noted by PT to reflect status and change in order to justify continued therapeutic intervention for the subsequent month. While this was not necessarily required, it was interesting that there was no consistency between OT and PT in this regard. In many cases, the PT progress notes were merely exact duplicates of the previous week's progress note with little or no new information as to progress or performance documented. Duplicates were noted as follows: • Individual #242: April (2/3), May (3/4), June (2/3), July (2/3), and August (same as July). A number of these were also the same from month to month. One note indicated that he had not received any therapy (7/23/10) that week "due to PTA on vacation." • Individual #222: May (2/2), June (3/3), July (4/4), August (2/3). With the exception of one note, each of these documented the same information including that she "smiled throughout therapy" and that the right ankle was swollen over this four month period. Documentation dated 9/10/10 stated that she had not received any PT during the week due to the holiday and the therapist's illness. There had been no coverage provided for this service during that time. • Individual #95: April (2/2), May (3/3), June (2/3), July (3/3), August (0/2). A number of these were also the same from month to month with the exception of the number of times he was seen by PT during the week. • Individual #349: May (3/3), June (2/3), July (2/2), August (3/4). Most of these were also the same from month to month with the exception of the number of times he was seen by PT during the week. • Individual #467: April (3/4), May (2/3), June (1/1). • Individual #188: April (2/2), May (4/4), June (4/4), July (4/4), August (2/2). All of these were exact duplicates with the exception of the number of times seen for PT during the week. The only information provided was that she tolerated the exercises and continued to benefit from PT. As stated above, there was an	

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		extensive resource assigned to this woman for at least six months to address a mere five to 10 degree change in range of motion at the hips and knees with no identification of functional change. **Standard: Within 30 days of development of the plan, it was implemented.** When a referral was made for OT/PT services, a consult or acute care assessment was completed and appeared to generally occur within 30 days, though most occurred immediately or within a few days. While a number of these were submitted, there were very few that had been completed in the last year. Based on review of the documentation submitted, it appeared that recommendations resulting from these assessments were generally implemented within 30 days, though, in many cases, the actual date of referral was not included in the report. There was no system of tracking referrals, response times, or follow-up submitted with the OT/PT tracking documentation requested. This was largely related to listing equipment issued rather than tracking assessments and follow-up. Changes recommended appeared to be added to the PNMPs and the date of revision was identified on most of the plans. **Standard: Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.** There was no evidence of training objectives for OT or PT in the PSPs submitted for review. Direct PT was provided to five or six individuals, but as described above, intervention plans were part of the acute care assessments rather than as training objectives within the PSP. Focus of intervention and established goals were most often related to range of motion and much less often related to functional skills. Emphasis on progress related to a specific measurable objective should be clearly and consistently stated. Clear rationale to discharge or to continue therapy should be tied to progress or lack thereof related to established measurable objectives. PNMPs were the primary intervention plan and while a focus was identified in the rationale for the plan, the assessment did not consistently provide a clear rationale for the specific selection of interventions for that individual. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** PNMPs addressed areas related to positioning, transfers, range of motion, and mobility, but interventions were limited related to promoting independence and skill acquisition.	

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		There were a very limited number of intervention plans beyond the PNMP and, as described above, the focus was predominately on range of motion for four of six PT interventions. Goals were not consistently functional or measureable. There were no measurable or functional outcomes identified for the one individual who had received OT services and this had actually been discontinued as of 8/13/10. Though it was stated that she had not had any functional change to her condition. There were no functional goals stated and measured upon which to base this statement or as a rationale to discharge her from OT services. PNMPs included staff instructions or precautions in the areas of mobility, transfers, movement techniques, and positioning, in addition to skin care and bathing. There were mealtime instructions, though these were minimal and inconsistent and generally referred the staff to the Dining Plan for specific instructions. The very brief communication section generally stated that the individual was verbal or referred staff to the Communication Dictionary. A list of assistive equipment and a description of hearing and vision were consistently provided in the plan. There was little information that identified how the individual was able to participate or ways in which skill acquisition and practice could be incorporated into the individual's daily routine. These strategies could promote teachable moments throughout the day and should be included in training, monitoring, coaching, and modeling conducted by the therapy staff. This greatly enhances opportunities for learning and independence. Many of these may be as subtle as allowing sufficient time for the individual to give a signal that he or she was ready for a transfer (e.g., 1-2-3-GO) in that the individual may be able to blink, vocalize, or nod his or her head on "GO." Or, the individual may be able to look in the direction of the transfer, for example, by looking over to the bed right before the transfer from the wheelchair. Other examples include the individual may be able to hold his or her foot up for placement of shoes and socks; during mealtimes when an individual who received hand over hand assistance had the ability to bring the spoon to his or her mouth and only required assistance to scoop; or that an individual could hold a second toothbrush or hairbrush in his or her hand or on his or her lap while being assisted to have teeth or hair brushed. These subtle abilities or potentials for skill acquisition often go unnoticed by direct support staff as they hurry to get everything done across their day. These types of activities would require that a baseline be established with regard to the individual's ability at the time of the OT/PT assessment, and then supports would be established to provide opportunities for practice of existing skills or for learning new ones. The clinicians did not appear to recognize that this was a need and tended to focus on basic clinical information in the assessments. This provided little foundation in the absence of also identifying functional limitations and the individual's potential for skill acquisition.	

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		As a result, they did not recognize needs for intervention and the staffing was grossly inadequate to address them. **Standard: The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used.** Each of the PNMPs reviewed listed specific assistive/adaptive equipment to address individual needs. The rationale offered in the assessment, however, was generally insufficient. The assessment should provide a clear analysis and rationale for equipment, rather than a rote assignment of these systems without clear and well documented need in regards to functional abilities, potentials, and health risk indicators. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** Measureable goals were uncommon in the design of most of the plans and, as a result, there was little in the documentation to quantify progress or regression. It was noted that the clinicians performed a very traditional clinical evaluation primarily measuring range of motion and checking the status of the individual's feet, but did very little to assess functional motor skills. In the case of Individual #435, the therapists evaluated sitting balance, but did not provide any support under his feet or pelvic stability. His legs were elevated in his wheelchair, but there was no discussion if this continued to be indicated until the monitoring team asked about it. The head rest on his wheelchair was crooked and there was no discussion of this until the monitoring team asked about it. There was evidence in some cases that observations were conducted in the homes and in the clinic. **Standard: On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results.** Only in the case that an individual received direct therapy, was progress reviewed routinely. A weekly progress note was written and, in the case of PT, there was a monthly acute care re-assessment completed. OT only completed weekly progress notes. Individuals were not otherwise reviewed on a monthly basis, and PNMPs were reviewed and changed on an as needed basis only other than during the annual assessment.	
P3	Commencing within six months of the Effective Date hereof and with	**Standard: Staff implements recommendations identified by OT/PT.**	Noncompliance

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	full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	Though equipment generally was available, implementation by staff was not consistently performed as intended per the PNMP. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, or pelvis not well back into the seat of their wheelchair. Some additional examples included the following: • Individual #432 was observed lying on a mat table during her day program. There were no positioning pictures to guide staff to do this appropriately. • Individual #35 was sliding out of his wheelchair so far that his head was level with the seat back and he was only held in by the seat belt as his feet were far forward of the footrests. No staff repositioned him and he was not repositioned prior to administering medications to him by the nurse. • Individual #281 was observed wearing a helmet during his meal, though this was not pictured in his Dining Plan. • Individual #171 was observed leaning to the left in her wheelchair during a meal. • Individual #322 was repositioned in his wheelchair during a meal. Staff left the tray on and lifted him up by his armpits. The PNMP Coordinator was present at that time and intervened. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** The only competency-based OT/PT training aspect of New Employee Orientation (NEO) was provided related to transfers and lifting. Lifting was the only PNM-related area for which re-training was provided. There were specific checklists used for this process, though the standard was performance of all indicators with 100% accuracy. Transfers observed using a mechanical lift were performed appropriately with no significant concerns noted by the monitoring team. At this time, however, evidence of additional training was limited to sign in sheets that did not outline the skills or performance criteria expected and, as such, would not be considered to be competency-based. **Standard: Staff verbalizes rationale for interventions.** In the examples above, staff generally were not able to discuss the rationale behind recommended interventions. The rationale for interventions and supports was not consistently included in the PNMP. This would be an important aspect of staff training as well as monitoring and coaching.	
P4	Commencing within six months of	**Standard: System exists to routinely evaluate: fit; availability; function; and**	Noncompliance

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	the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**condition of all adaptive equipment/assistive technology.** The current system of PNMP monitoring was generally limited to availability and condition, rather than function and fit. Function and fit were consistently reviewed on an at least an annual basis via evaluation, at the request of the PST, and upon referral when a problem was identified. Proactive review of staff performance was reportedly conducted on an informal basis by therapy clinicians and PNMPCs. Tracking and documentation were not yet in place, however, the PNMPCs were more consistently providing staff training when issues and concerns were identified, both on the spot and with inservices. Per the work order tracking sheets submitted, maintenance checks were conducted infrequently for wheelchairs, for most only one or two times in a year. Repairs and modifications occurred more often. Direct support staff were responsible for conducting daily maintenance checks and cleaning of all equipment. The monitoring team noted a number of wheelchairs that were in need of cleaning. Most issues identified were addressed on the date of the request, though in some instances the work took significantly more time. It was unclear as to why this would be. For example, Individual #498 received a 14-inch plush headrest with Linx mount on 8/25/09 following a request on 4/8/09. It took three weeks to adjust footrests for Individual #4 and the Gunnell wheelchair was modified so the brakes would work. It took from 11/24/09 to 2/12/10 to adjust brakes for Individual #523. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** As stated above, monitoring typically was primarily limited to availability and condition of equipment by the PNMPCs, rather than efficacy of the interventions. By report, however, the therapists were supposed to initiate PNMP and mealtime monitoring and documentation for those individuals who were deemed to be at highest physical and nutritional risk on a weekly basis and to provide validation of monitoring by the PNMPCs. There were 221 individuals who were listed with PNM needs and approximately 223 individuals with PNMPs submitted. This represented approximately 54% of the current census at MSSLC. The identification of those at greatest risk is discussed in Section O above. It would be anticipated, as the system of risk identification was further developed and integrated, this system would drive the frequency of monitoring by the clinicians. As described above, there also appeared to be monthly review of direct therapy interventions, but documentation of this was not consistent and only a limited amount was submitted in the documents requested by the monitoring team.	

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		Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. Monitoring was conducted to address mealtimes, as well as communication, transfers, and positioning in the homes. Bathing/showering and toileting equipment was reviewed for condition and cleanliness, and there was evidence of routine monitoring of transfers, positioning, and support. Mealtime monitoring conducted was noted on the mealtime observation forms. There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. A new form was implemented in August 2010 in an effort to combine the PNMP and mealtime monitoring process. The monitor was to mark the type of activity including meal, snack, bathing, medication administration, or oral care. There had been a tremendous number of monitoring sheets completed in the last three months predominately by the PNMP coordinators and some by Pam Harlan, COTA. There were no sheets completed by other professional staff noted. Approximately 212 individuals were monitored, many on multiple occasions. There was no method to track the frequency of observation conducted for specific individuals who were considered to be at highest risk, though a schedule had recently been developed. The monitoring team requested PNM monitoring forms completed in the last quarter. A sample of 50 forms for 49 individuals completed for across two months rather were reviewed. Another 15 monitoring forms were completed for locations, such as specific homes or day programs, but not for a specific individual. Monitoring forms reviewed included July 2010 (39) and August 2010 (26) by eight different monitors. There was one individual monitored two times and all others were monitored only once in July 2010 and August 2010 in the sample reviewed. General findings were as follows: • No concerns noted: 39% • Partial concerns noted: 45% • Non-compliance with one or more element: 11% • "No" designation referred to "not observed" or not applicable" rather than non-compliance with an element: 27% It was unclear how the partial designation was to be used. For example, in one case, the wheelchair was noted to need cleaning, yet the monitor marked partial. In many cases,	

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		partial was marked for position, but no specifics were identified. Other forms documented that care plans or pictures needed to be updated, yet partial was marked for that item. **Standard: On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.** The PNMP Coordinators had recently been retrained and were involved in ongoing on-the-job training, however, the current system was not driven by health risk concerns. There were a number of individuals monitored that were identified as independent with transfers and repositioning and, as such, would not be considered at high risk for physical and nutritional support concerns. There was no tracking system to analyze and report findings to drive needed staff training and to ensure system change as indicated. Validation of the PNMP Coordinators had not been completed by the therapy clinicians. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** See above. **Standard: For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff .** This was reported to be true by therapy clinicians, however, because training was not competency-based, there was no assurance that those who were most at risk were assisted by competent and well-trained direct support staff. PNMP Coordinators were observed on several occasions intervening and providing appropriate coaching to direct support staff. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** There was no documentary evidence that issues identified during monitoring had been remedied or that home supervisors were notified of the findings. There was no tracking system to enable systemic analysis of findings or to track follow-up. **Standard: Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available.** There was a tracking system for adaptive equipment and this was a significant aspect of	

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		PNMP monitoring, however, this was not completed with sufficient frequency to effectively identify concerns. **Standard: Data collection method is validated by the program's author(s).** There were no plans implemented, other than the PNMPs, at this time, and no data collection was occurring, so validation was not indicated.	

Recommendations:

1. OT and PT staffing was alarmingly inadequate and aggressive recruitment is an immediate need to ensure adequate supports and services were available to those with therapy needs.

2. The frequency of PNMP monitoring needs to be driven by risk level; those at highest risk must be monitored with sufficient frequency to ensure adequacy and efficacy of the supports provided as well as the accuracy of staff implementation of these supports.

3. PNMP Coordinators continue to require structured, functional, competency-based training that includes didactic presentation of monitoring strategies and validation of competence through an ongoing "monitor the monitor" process, whereby they are observed during the monitoring process and compared to a licensed clinician. Tracking of this should occur to clearly document that each PNMPC has received the same training and frequency of oversight and review.

4. Review the current system of comprehensive assessments and updates to create a distinction between them without sacrificing sufficient findings for the design of appropriate interventions and supports. Focus should be on guidelines to conduct the analysis of findings, as well as providing consistent documentation of the rationale for the interventions and supports recommended by the clinicians. The updates should include a health status update, review of supports and services over the previous year, individual response to the supports, and progress.

5. Additional focus for the development of improved assessments should address health risk indicators and clear relationship of interventions selected to address them.

6. Develop treatment plans that have specific measurable and functional goals. Ensure that documentation relates to those goals. Consider integration of these into the PSP process as SPOs. Interventions should begin to shift to skill acquisition rather than foundational supports via assistive equipment and the PNMPs. These may be accomplished via direct service as well as collaboration in the development of training plans in other areas including the home and day/work programs.

7. Ensure that the most current assessments and other documentation were present in each individual's record at all times. If the system is adopted to complete comprehensive assessments every three years with interim updates, the comprehensive assessment should remain in the record for three years with the interim updates until a new comprehensive assessment is completed to replace it. Updates should make reference to the comprehensive assessment and provide analysis of changes from the baseline findings in that report.

8. Ensure that performance competencies are clearly defined for staff training that is skills based. Additional training of supervisors and PNMPCs may be needed to ensure that they have the skills they need to train others and understand how to establish competent skill performance.

The following are offered as additional suggestions to the facility:

9. It is recommended that the therapy clinicians embrace the opportunity to work the ATP certified vendor to provide optimal seating assessments with fabrication of appropriate seating options for individuals. The opportunity to try out additional equipment such as standers would provide an added dimension to the supports and services available to those who live at MSSLC.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o MSSLC Dental Data (July 2009 – July 2010) • Procedures completed o Dental records for the individuals listed in Section L o Dental Database Appointments (3/1/10 - 8/11/10) • Refusals • Restraints o Oral hygiene ratings Interviews and Meetings Held: o Dolores Erfe, M.D., Medical Director o John Sponenberg, DDS, Dental Director o Bennie Kirven, Dental Assistant II Observations Conducted: o Dental department o Dental clinic
	Facility Self-Assessment: The facility's POI for section Q indicated substantial compliance with several provisions, including requirements for annual assessments and emergency care. The facility also indicated substantial compliance with the requirement to have desensitization plans in place for individuals who refused treatment. The facility found itself to be in noncompliance in other areas. The monitoring team's efforts to assess dental services were hampered by a lack of data to substantiate substantial compliance. The primary method of validating compliance with annual assessments is to review a list of individuals, and the dates of the most recent annual exams. This was not provided. A record sample would then be chosen to corroborate the findings presented. Other data requests for individual-specific data were met by providing procedural numbers. The monitoring team acknowledges that the clinic was seeing a substantial number of individuals and providing a variety of services. Due to the inability to verify key data elements, as well as a lack of a comprehensive strategy on the part of the facility to increase oral hygiene in the homes, the monitoring team found both provision items to be in noncompliance.

	Summary of Monitor's Assessment: Assessing the facility's compliance with this provision was difficult based on the data submitted. Document requests for lists of individuals in some instances were not met. Instead, the monitoring team was provided a coded spreadsheet that contained numbers for procedures and not a list of individuals. A second spreadsheet was provided with a list of individuals and appointment dates. The data did not verify that the appointment date met the timeframe for the annual appointment. In fact, the spreadsheet did not specify that the appointment date listed was the annual appointment date. Record reviews indicated the individuals received a variety of services in the dental clinic and without the use of restraints. Over 350 appointments were missed. This represented a tremendous amount of wasted opportunities considering that provision of oral hygiene in the homes appeared problematic. Many individuals were returning to dental clinic on a monthly basis to have the hygienist perform tooth brushing and cleaning. Informal desensitization plans and other techniques were documented in the spreadsheet provided. This appeared to have resulted in some success.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	Dental services were provided in the onsite dental clinic. At the time of the onsite review, services were provided by a dental director, staff dentist, two dental hygienists and two dental assistants. The dental director had been employed at the facility for 27 years. The staff dentist was employed less than one month and, surprisingly, submitted his resignation during the week of the onsite review. The dental assistants worked directly with the dentists. The department did not have any clerical support and the dental director reported this was problematic in terms of scheduling appointments and maintaining adequate data. The dental director was observed to interact extremely well with the individuals who appeared quite comfortable in his presence. He conveyed genuine concern for the individuals and the quality of services provided. The dental director explained that the facility had 100% compliance with the requirement for annual exams with the exception of those who refused exams. He also reported that all individuals received a dental evaluation within 30 days of admission. Edentulous individuals were seen annually. The standard recall appointment for the facility was three months. The dental director reported that refusals were a major problem.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Due to the lack of clerical support, the dental director reported difficulty keeping up with the various forms and data. Data were tracked by spreadsheet. A request was made for data related to oral hygiene status (aggregate data), the number of clinic visits, and number of visits for exam and prophylaxis, restorative treatments, endodontic, and emergency treatments. The monitoring team was provided three spreadsheets, one each for the dental director and the two hygienists. Multiple columns of data were scratched off. The printouts provided had missing headings and the documents were generally confusing. The spreadsheet contained codes for the various dental procedures. An additional document was given to interpret the coding used on the spreadsheets. The "TXMHMR 1995 Dental Code-Procedures and Nomenclature" contained a few hundred items. The codes from the spreadsheet needed to be matched to the document codes to determine how many visits and what types of visits occurred in the dental clinic. The spreadsheet also contained data on items pertaining to employee issues, such as leave use and meeting attendance. The data appeared to represent the number of procedures, yet it also contained elements that would be based on the number of individuals. It also appeared that the spreadsheets contained overlap in data. This could not be determined with certainty because only numbers were provided, not the names of the individuals. Even so, the spreadsheets for the three practitioners were reviewed. The data for the dental director from July 2009 – July 2010 showed completion of 671 recall visits, 86 limited oral exams, 409 annual exams, 505 x-rays, 64 panorex films, and 184 restorative procedures, such as resins and amalgams. All annual assessments must be completed by a dentist and during the timeframe reported, only one dentist was at the facility. A total of 409 annual visits for a one year period would indicate that a significant number of assessments were not completed. A second spreadsheet contained information on clinic visits for the past six months. The date included in the spreadsheet was not labeled as the date of the annual assessment. The monitoring team made the assumption that this was the annual assessment date. Compliance with the requirement for annual assessments could not be determined from these data alone. The individuals supported at MSSLC received preventive and restorative procedures. In 30 of 30 (100%) records reviewed, there was evidence that every individual received frequent dental services and had annual exams completed in a timely manner. The dental clinic needs assistance in developing data collection tools that will allow reliable and accurate data to be reported.	

#	Provision	Assessment of Status	Compliance
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	One of the barriers in the provision of dental services to persons with developmental disabilities is refusal of treatment. The dental director reported that refusals were a major problem. When individuals refused, they were re-scheduled within the 30 days. The clinic recently implemented the use of a form "Medical Procedure Report" in those instances where an individual refused. This document was addressed to the PCP and provided the reason the procedure was not completed. It also made recommendations for action including: (a) re-attempting procedure (b) sedation, (c) discontinuing procedure (d) repeating at alternate facility, or (e) alternate testing needed. The tracking spreadsheet for the dental director alone indicated that from July 2009 – July 2010, there were 240 broken appointments and 111 refusals. Multiple reasons were cited for missed appointments and included the inability to find the chart, individual out, lack of staffing, lack of transportation, and hospitalization. The dental director unequivocally stated that it was his opinion that dental care and oral hygiene was not considered a priority and oral hygiene in the homes was not adequate. To compensate for this, individuals were brought back to clinic frequently, with many individuals being seen monthly. In an effort to provide care and improve hygiene for individuals who refused care, the director had implemented "informal desensitization" plans. The PSPs of most individuals who refused contained comments from the dental director regarding this approach. The intent in having individuals return monthly to dental clinic was to gradually introduce them to staff until they were comfortable enough to attempt treatment. The dental records of 30 individuals were reviewed. Two of the individuals were recent admissions. One was edentulous and one had refused dental clinic evaluations since 2008. The findings are summarized below: • Oral hygiene was rated good in three of 28 (10.7%) individuals. • Oral hygiene was rated fair in 20 of 28 (71.4%) individuals. • Oral hygiene was rated poor in 5 of 28 (17.8%) of individuals. • Timely initial assessments were documented in two of two records reviewed. • Timely annual assessments were documented in 29 of 30 (97%) records reviewed. • Individuals with timely initial assessments: two of two (100%). Permanent dental records were maintained in the dental clinic. In recent months, the staff of the dental clinic had begun documenting in the interdisciplinary progress notes.	Noncompliance

#	Provision	Assessment of Status	Compliance
		One concern with regards to the use of the IPN was that notes in that format are usually not standardized and that increases the likely that key information is not present. Legibility of some of the dental notes also seemed to be a problem and annual assessments were not standardized. Nonetheless, the teams appeared to have adequate understanding of the dental issues of concern and discussions related to desensitization plans were beginning to be documented in the records. The following represent a sample of the types of interventions documented in the record reviewed: • Individual #278 began refusing all medical appointments including dental clinic in 2008. All attempts to provide treatment in dental clinic had failed. There were comments in the records related to his refusal and concern that desensitization did not appear appropriate since appropriate reinforcers could not be identified. On 6/29/10, the PST met with psychology to develop a desensitization plan. On 9/3/10, it was documented that the individual was successfully brought to the dental clinic. • Individual #326 had an oral hygiene rating of poor. His PSP detailed very specific instructions on how he might be encouraged to brush his teeth longer through the use of popular music. Data provided to the monitoring team indicated that no chemical restraints were used in dental clinic in 2010. The use of mechanical restraints declined from January 2010. Mechanical restraints reported by dental clinic: Restraints 2010 January 5 February 1 March 2 April 0 May 1 June 0 July 0 Persons who could not be managed with behavioral approaches were referred out to the community for treatment.	

Recommendations:

1. The facility must determine the reasons for the large number of missed appointments and take corrective actions to decrease that number.
2. The facility should review aggregate data on oral hygiene to determine if there are trends or patterns.
3. Individuals who continue to refuse treatment should be assessed for the appropriateness of desensitization plans.
4. Given the volume of visits in the dental clinic, the position being vacated by the newly hired dentist should be filled.
5. The dental clinic needs clerical support as well as assistance in maintaining data for the clinic.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **<u>Documents Reviewed</u>:** o List of PNMT members o Continuing education documentation for SLPs o Communication Services policy #016, 10/7/09 o Communication Master Plan Data Base, dated 7/20/09, 8/7/09, 8/18/10 o Augmentative Communication/Assistive Technology Evaluation template o Speech-Language Evaluation-Baseline template o Augmentative Communication Consultation reports o Completed Speech Equipment Monitoring Sheets July 2010 o QA monitoring forms for Section R, June/July/August 2010 o Master Plan for Communication Disorders, Revised 8/7/09, dated 9/15/09 o Communication Dictionaries (approximately 100 submitted) o List of individuals with PNMPs o PNMPs (approximately 223 submitted) o Alpha Client List with admission dates (8/24/10) o Speech Equipment Monitoring Sheet template o List of Individuals with AAC (per database dated 8/18/10) o Speech-Language Evaluations for the following: • Individual #431, Individual #244, Individual #122, Individual #578, Individual #17, Individual #269, Individual #498, Individual #108, Individual #218, Individual #581, Individual #110, Individual #480, Individual #310, Individual #328, and Individual #297, Individual #139, Individual #135, Individual #408, Individual #392, Individual #182, Individual #519, and Individual #240 o PSPs and Addendums for the following: • Individual #498, Individual #49, Individual #265, Individual #240, Individual #1, Individual #257, Individual #100, Individual #433, Individual #449, Individual #182**,** Individual #392, Individual #135, Individual #269, Individual #139, Individual #581, and Individual #218. o Staff Training documentation related to inservices conducted including Medical communication, environmental controls, general communication boards, communication dictionaries, Super Talker, communication instruction sheets, Big Mack switch, augmentative and interactive communication, dated 10/09 through 07/10 o Staff New Employee training curriculum *Communication and People with Special Needs* o Personal Record documents including: Personal Support Plans and Addendums, Integrated Progress Notes (previous three months), Physicians Annual Medical reviews, Active Problem list, Significant Past Medical History, HST Assessment Tools, Comprehensive Nursing Assessment, Quarter Nursing Quarterly Assessments for the last PSP year, Habilitation Therapies section, PNM

	Monitoring for the last six months year, Mealtime Monitoring for the last six months, Communication monitoring forms for last six months for: • Individual #35, Individual #256, Individual #488, Individual #196, Individual #322, Individual #41, Individual #216, Individual #438, Individual #148, Individual #435, Individual #411, Individual #347 Individual #523, Individual #405, Individual #268, Individual #164, Individual #431, Individual #589, Individual #59, Individual #486, Individual #331, and Individual #212 **Interviews and Meetings Held:** o Gary Sandler, MOT, OTR, Interim Habilitation Therapies Director o Cara Mattson, MS, CCC/SLP o Jean Reboli, MS, CCC/SLP o Deann O'Lenick, MS, CCC/SLP o Jeaneen Abram, LSLA o Elaine Pruitt, Speech Technician o Various direct support staff in homes and day program areas **Observations Conducted:** o Living areas o Dining rooms o Day programs o Habilitation Therapies clinic areas o Assessment in AAC Lab for Individual #435
	Facility Self-Assessment: Per the POI, MSSLC reported that all elements and actions steps were in noncompliance in section R, communication. A number of elements made reference to the staff shortage and attributed inconsistency with implementation of processes to that. Others made reference to the new PSP process and that it would include information related to AAC, how the individual communicated, and how to incorporate communication strategies for staff use to enhance communication. It will be critical for the clinicians to recognize, however, that the information incorporated will likely need to be provided by them because the PSP process will only provide a framework. It will be up to the PST members to ensure appropriate integration of key information and the development of interventions and supports with functional measurable outcomes and goals for implementation of effective individual plans. A number of other elements referred to the Master Plan as a guide for completion of assessments prioritized based on need, change in status, or as requested by the PST. A number of processes identified as integral to specific elements were listed as in development, including some policies to be developed by MSSLC and the state office. It appeared that several elements were dependent of the implementation of a new assessment format. There were no data offered for any of the elements listed in this section. Implementation of the data analysis aspect of the monitoring system and collaboration with QA to evaluate

	actual performance will provide a better picture of status and progress with each of the elements in this section. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the POI self-assessment findings of noncompliance for all provision items.
	Summary of Monitor's Assessment: Per staff report, the speech staff were not currently able to provide sufficient and adequate communication supports and services based on individual needs due to inadequate staffing at the time of the onsite review by the monitoring team. Insufficient staffing in the area of communication had been cited as a serious concern during the baseline review. Now with even fewer staff, it would not be possible to adequately meet the needs of the individuals living at MSSLC in these two critical service areas, that is, in communication and mealtimes. Of the 38 assessments submitted and reviewed, approximately 76% identified individuals with significant expressive and/or receptive language deficits, and many of these individuals presented with challenging behaviors with related communication concerns. There was evidence that only one individual received direct communication intervention and there were only six others who were recommended for some type of AAC system beyond the communication dictionary provided. Per the AAC database submitted, there were only 33 individuals listed with some type of AAC system and another 12 individuals who were provided some type of environmental control device, such as a CD player or vibrating pillow with switch access. It appeared, however, that some who were to use these devices did not have consistent access to them. While much work had been done to retrieve some devices that had previously been issued and were not effective or appropriate, there were still many who would likely benefit from the correct communication system with the right supports. While assessments generally contained some basic elements, there was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish goals and objectives for communication supports and interventions. It was also often not clear as to how effective the current methods used by each individual were within their daily routine. The clinicians reported what system the individual had and that it met their needs, but not how it was used and whether or not it was effective. Assessments were lengthy, and it was reported that they required significant professional time to complete. A dictation service had been utilized to address paperwork delays, but this had been only marginally effective. Most staff were observed to be communicative and interactive with individuals during a variety of activities, including day programming activities and, in some cases, mealtimes, however, there was little interaction noted during the in-between times, such as before meals when most individuals were observed to be sitting around and waiting. Much of the interaction observed was utilitarian to a specific task with little other interactions that were meaningful. Devices noted in the day programs were not always placed where the individual had ready access to the device and, as a result, spontaneous opportunities to use the system and seek a response from others or reinforcement of communication efforts were limited.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**Standard: The facility provided an adequate number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. Training included augmentative and assistive communication.** At the time of the onsite monitoring tour, there were two full-time contract SLPs employed at MSSLC, working four 10-hour days weekly (Cara Mattson, MA, CCC/SLP and Jean Reboli, MS, CCC/SLP), in addition to a part-time contract therapist, Deann O'Lenick, MS, CCC/SLP, working an average of 20 hours a week. Copies of credentials were not submitted, so it was not possible to verify the current status of their licensure at this time. There was also a full-time Speech Assistant, Jeaneen Abram, LSLA, also generally working four 10-hour days, and a speech technician (Elaine Pruitt). Each of these staff reported working beyond this at times as necessary. There were no CVs submitted for any SLPs. Ms. Mattson and Ms. Reboli submitted documentation of their attendance at the Texas Assistive Technology Network Statewide Conference in June 2010 for a total of 14 hours and 12.5 hours respectively. Verification of Ms. Reboli's hours was not submitted. Ms. O'Lenick submitted evidence of attendance at two communication-related continuing education courses during 2010 for a total of 24 hours. Verification of these hours was not submitted. Per staff report, the speech staff were not currently able to provide communication supports and services based on individual needs due to inadequate staffing at the time of this onsite review. Ms. Mattson and Ms. Reboli each had primary duties related to dysphagia and mealtime, in addition to those related to the provision of communication supports. While Ms. O'Lenick's primary focus was related to communication needs during the hours she provided each week, she also addressed dysphagia/mealtime concerns as required. The Speech Assistant was available to assist with supports and services related to communication only, but was not permitted per the state practice act to address needs related to dysphagia or mealtime. She was able to assist with data collection for assessments, but was not licensed to provide clinical analysis or recommendations. With a census of 416 at the time of this review, each of the full-time speech-language pathologists was responsible for a potential caseload of nearly 175 individuals in both of these areas, with the part-time clinician responsible for nearly 70 individuals. This was an increase in caseload size from the baseline review by 25 individuals per full-time clinician. A full-time clinician working at the time of the baseline review was no longer employed at MSSLC. While there had been two additional full-time therapists during the summer months, only Ms. O'Lenick had agreed to continue at least through December 2010 on a part-time basis. As a result, coverage of this	Noncompliance

#	Provision	Assessment of Status	Compliance
		reduction in staff continued to be inadequate. Insufficient staffing in the area of communication had been cited as a serious concern during the baseline review. Again, given this ratio, it would not be possible to adequately meet the needs of the individuals living at MSSLC in these two critical service areas, communication and mealtimes. By report, there was one position for a full-time SLP posted. Based on interview and review of the POI submitted, MSSLC concurred that it was not in compliance with this provision of the Settlement Agreement. **Standard: Communicative Aids and Speech Generated Devices (simple and complex) were provided to individuals based on need and not staff availability. All individuals in need of AAC, received AAC. SLPs actively participated in all facets of care in which communication is relevant.** Of the 38 assessments submitted and reviewed, approximately 76% identified individuals with significant expressive and/or receptive language deficits. Though requested, there were no communication assessments submitted for Individual #411, Individual #41, Individual #212, Individual #336, Individual #294, Individual #203, Individual #59, or Individual #164. There was evidence that only one individual, Individual #216, received direct communication intervention and this was related to AAC use. There were only six others of those individuals for whom assessments were submitted who were recommended for some type of AAC system beyond the communication dictionary provided, though there were many others listed as non-verbal per the database submitted and, moreover, the assessments reviewed identified significant communication deficits for the majority of individuals. Another two individuals were recommended for environmental control systems. In response to the monitoring team's request for a list of individuals who received direct speech services with the focus of intervention, a treatment plan and two progress notes for Individual #216 dated 7/26/10 were submitted (for services provided in July 2010 and August 2010) reflecting some level of direct service with a plan to continue with the treatment plan as written. As there was only two notes submitted, it was not clear if direct service continued at the time of this onsite review. An additional six Augmentative Communication Consultation reports were submitted, written by Kim Henderson, MS, CCC-SLP, the speech clinician described above who was previously working during the baseline review, but was no longer employed at MSSLC. Each of these consults, dated 6/7/10, had recommended application to Specialized Telecommunications Assistance Program for funding of a high tech AAC device for	

#	Provision	Assessment of Status	Compliance
		Individual #228, Individual #146, Individual #279, Individual #170, Individual #53, and Individual #448. These consults reflected that each of these individuals had been offered trials to use specific Dynavox devices. There was no indication as to the extent, frequency, or duration of direct services provided by Ms. Henderson and if, in fact, this service continued for these six now that she was no longer employed at MSSSLC. The recommended equipment was not listed for any of these individuals on the Communication Master Plan Database and, moreover, Individual #279and Individual #170 were not listed with any AAC equipment or Communication Dictionary. Per the AAC database submitted, there were only 33 individuals listed with some type of AAC system and another 12 individuals who were provided some type of environmental control device, such as a CD player or vibrating pillow with switch access. It appeared, however, that some who were to use these devices did not have consistent access to them: • Individual #216 was identified as participating in direct speech therapy for use of an AAC device and use of a voice output device was recommended throughout his day, though none was listed. • Individual #486 received a baseline Speech-Language Evaluation on 7/12/10. Her PSP dated 07/20/10 made no reference to this assessment and indicated only that she communicated non-verbally, such as with body movements and vocalizations. It was listed that she had a Communication Dictionary. The assessment was not signed (perhaps a page was missing from the copy submitted). It was recommended that she should continue with switch activation as part of her plan, but there was no mention of switches in the PSP submitted as current. Only the Communication Dictionary was listed in the Communication Master Plan Database. • In the assessment for Individual #331, it was recommended that he have an environmental control system. This was not listed in the Communication Master Plan Database. The date of evaluation listed was 11/9/09, the date of assessment listed in the header was 1/6/09. There was no signature or date on the copy submitted. The assessment was stamped 1/12/10. The PSP dated 1/6/10 listed a speech assessment dated 1/4/10. There was no environmental control system listed as provided to Individual #331 in the database dated 08/18/10, seven months after the PSP that indicated that all recommendations including the environmental control system had been approved by the PST. By report, the SLPs did not routinely attend the PSP meetings. By report, the PNMP Coordinators attended a number of the PST meetings held for some individuals. It did not appear that SLPs participated in a variety of settings to ensure appropriate implementation of communication systems, and there was no evidence in the	

#	Provision	Assessment of Status	Compliance
		assessments that observations were conducted across settings, but rather clinicians depended largely on observations noted during a single session in the clinic setting or on the report of home staff. In one case there was a discrepancy in what the SLP noted in the Speech-Language Evaluation Update dated 3/2/10 with direct support staff's observations for Individual #405. The clinician reported that his current means of communication included blinking his eyes twice for "yes" and once for "no" and that he held his breath to set off the alarm of his monitor to gain attention from staff. A system of environmental control was recommended. His PSP dated 3/3/10 indicated that staff reported the opposite "yes/no" response by Individual #405. It was documented that the PST had decided that training was to be provided for improved consistency. The PSP Action Plan #2 listed training related to "blinks eyes to answer yes/no questions." There was no measureable goal identified and the responsible person was listed as Education and Training staff. There was no evidence that the SLP would be involved in this process. An environmental control system was recommended by the speech clinician and listed in the database as provided to him as of 8/18/10.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	**Standard: All individuals in need of AAC were identified as being in need of AAC.** The baseline assessment format had been designed to identify each individual's need and potential to benefit from AAC systems to enhance his or her communication skills. Each individual had been previously screened and ranked based on potential need for AAC per the Master Plan for Communication Disorders dated 9/15/09. The priorities were outlined as follows: • Priority 1 = Individuals who were non-verbal, who had a behavior plan, and who were not considered to be high risk medically • Priority 2 = Individuals who were non-verbal, who did not have a behavior plan and who were considered to be high risk medically; individuals who were non-verbal without a behavior plan and all medical risk levels; and individuals who were partially verbal with a communication dictionary in place • Priority 3 = Individuals who were verbal, with or without a behavior plan and all medical risk levels The Master Plan outlined that those with a Priority 1 were provided comprehensive baseline communication assessments by 5/31/10, Priority 2 between 6/1/10 and 5/31/11, and Priority 3 to be completed after 6/1/11. Each individual with a communication system was to receive an annual update and reevaluation was to be driven by changes in function determined via the PST and speech screenings.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>During interview with the SLP clinicians, they discussed their progress with this plan. They reported that they were nearing completion of the baseline evaluations for all individuals who had been identified as Priority 1 (approximately 167 per their verbal report). They reported the deadline as 7/31/10, however, rather than the 5/31/10 deadline documented in the plan. The list submitted with the Master Plan document identified only 21 individuals as Priority 1. A spreadsheet which reflected the most current plan for completion of assessments was submitted and dated 8/18/10. There were approximately eight of the 84 individuals listed who were identified as verbal while the others were listed as nonverbal. Of the 38 assessments submitted and reviewed, approximately 76% identified individuals with significant expressive and/or receptive language deficits.

Upon review of the AAC Spreadsheet submitted rankings and assessments were listed as follows:

<table>
<tr><td></td><td>Priority 1</td><td>Priority 2</td><td>Priority 3</td><td>No Priority</td></tr>
<tr><td>Screening</td><td>45</td><td>7</td><td>0</td><td>32</td></tr>
<tr><td>Evaluation Completed</td><td>39</td><td>5</td><td>0</td><td>32</td></tr>
<tr><td>Evaluation Needed</td><td>6</td><td>2</td><td>0</td><td>0</td></tr>
</table>

As noted above, there were a number of individuals listed who did not have a screening rank listed, but had evaluations completed. Verbal report by staff indicated that there were approximately 49 individuals who were ranked Priority 2 and 25 who were ranked Priority 3. Clearly this spreadsheet did not reflect the screening rank and assessment status of all the individuals living at MSSLC at the time of the onsite review and did not correlate with the original plan developed.

The SLP clinicians also reported the following:
• Cara Mattson, MA, CCC/SLP indicated that all Priority 1 individuals assigned to her had been seen, but she was 15 reports behind. She projected that all would be completed by mid-October 2010.
• Jean Reboli, MS, CCC/SLP indicated that she had three remaining Priority 1 assessments to complete and that all would be completed by 10/1/10.
• Deann O'Lenick, MS, CCC/SLP reported that she was to complete eight Priority 1 assessments during the week of the onsite review, was working on reports for four others, and that all would be completed by 9/20/10.

This did not include assessments for those newly admitted which numbered approximately two to six per week, by report, and included a swallowing assessment in addition to a communication assessment for those individuals. The client list submitted</td><td></td></tr>
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		and dated 8/24/10 listed approximately 66 individuals who had been admitted to MSSLC during the 12 months prior to the onsite review. Documents requested by the monitoring team included the five most current assessments and associated PSPs for each clinician along with the current PSP for those individuals. Speech-Language Baseline Evaluations were submitted by speech clinicians currently providing services. A number of these would not be considered recent because they had been completed five to six months prior to the onsite review. The assessments submitted included the following with dates reflected in parentheses below: Deann O'Lenick, MS, CCC/SLP • Individual #108 (7/21/10) • Individual #581 (6/11/10) • Individual #110 (8/11/10) • Individual #480 (8/9/10) • Individual #244 (8/2/10) Jean Reboli, MS, CCC/SLP • Individual #498 (3/23/10) Cara Mattson, MA, CCC/SLP • Individual #240 (7/20/10) • Individual #392 (6/7/10) • Individual #310 (6/7/10) • Individual #135(6/3/10) • Individual #139 (4/19/10) • Individual #182 (4/4/10) Additional baseline assessments were also submitted by Stacy Catero, MS, CCC-SLP who had worked under contract during the past summer for MSSLC, but was not working at the time of this onsite review. They included: Individual #17 (7/12/10), Individual #218 (6/22/10), Individual #269 (6/22/10), Individual #578 (6/30/10), Individual #122 (7/19/10), Speech-Language Update Evaluations were also submitted including: Jean Reboli, MS, CCC/SLP • Individual #519 (5/17/10) • Individual #405 (3/2/10) The corresponding PSPs were not submitted for each of the assessments submitted as	

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		requested; only eight of 19 were received. The dates listed below in parentheses were the dates of the PSP or addendum submitted for each individual. In some cases, it was reported that the PSP had not been scheduled (Individual #17, Individual #578, Individual #480) or had not yet been held (Individual #122, Individual #110, and Individual #244). In other cases, the PSP had been held, but only a PSP Addendum discussing the speech evaluation was submitted and included: Individual #519 (7/16/10) and Individual #581 (6/28/10). A PSP Addendum (6/23/10) was submitted for Individual #269, but it was not related to the speech assessment, but rather a recent move to Barnett Unit. PSPs were submitted as requested for the following individuals: Individual #405 (3/3/10), Individual #310 (6/30/10), Individual #182 (4/27/10), Individual #139 (5/11/10), Individual #135 (6/21/10), Individual #392 (6/29/10), Individual #240 (8/12/10), and Individual #498 (5/20/10). No PSPs or notations were submitted for Individual #218 or Individual #108. Additionally, communication assessments and PSPs were requested for eight individuals newly admitted to MSSLC and included: • Individual #336 • Individual #408 • Individual #294 • Individual #182 • Individual #392 • Individual #203 • Individual #297 • Individual #272 Baseline assessments and PSPs were submitted for Individual #182 and Individual #392 related to the request for most current assessments described above. Baseline communication assessments were also submitted for Individual #408, Individual #297, and Individual #272, though PSPs, addendums, or notations were not submitted. Neither assessments nor PSPs were submitted for the other three individuals as requested (Individual #336, Individual #294, and Individual #203). There was a notation that the assessments for these individuals were still with the dictation service used by the department and there was no explanation for the missing PSPs. A variety of documents from the personal records including the SLP assessments of a sample of 22 individuals selected by the monitoring team were also requested including: • Individual #35, Individual #256, Individual #488, Individual #196, Individual #195, Individual #41, Individual #216, Individual #438, Individual #148, Individual #435, Individual #411, Individual #347, Individual #523, Individual #405, Individual #268, Individual #164, Individual #431, Individual #589,	

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		Individual #212, Individual #59, Individual #486, and Individual #331. Of the 22 records requested, only 21 were received. No records for Individual #59 was submitted as requested. Communication assessments from the active records were submitted as follows with the date of the assessment(s)and PSP in parentheses: • Individual #35 (4/4/09, 1/18/10 and PSP: 3/8/10) • Individual #256 (5/18/93, 8/1/10 and PSP: 12/15/09) • Individual #488 (9/9/10 and PSP: 4/19/10) • Individual #196 (7/20/09 and PSP: 9/16/09) • Individual #195 (9/28/87, 3/28/05 and PSP: 3/9/10) • Individual #41 (no communication assessment submitted from individual record and PSP: 10/5/09) • Individual #216 (6/9/10 and PSP 3/15/10) • Individual #438 (5/13/94, 12/27/05 and PSP:12/1/09) • Individual #148 (9/26/91, 5/1/06, 2/24/10 and PSP: 4/19/10) • Individual #435 (12/1/05 and PSP:11/17/09) • Individual #411 (no communication assessment submitted from personal record and PSP: 1/7/10) • Individual #347 (10/22/92, 9/29/95, 7/24/01, 6/9/09 and PSP: 5/13/09) • Individual #523 (3/22/10, 5/8/10 and PSP: 11/2/09) • Individual #405 (3/2/10 and PSP: 3/3/10) • Individual #268 (3/3/05 and PSP: 1/14/10) • Individual #164 (no communication assessment submitted from personal record and PSP: 3/22/10) • Individual #431 (5/26/09, 5/24/10 and PSP: 4/20/10) • Individual #589 (5/28/96, 4/15/99, 2/25/02, 1/25/05 and PSP:12/8/09) • Individual #212 (no communication assessment submitted from personal record and PSP: 9/9/09) • Individual #486 (7/12/10 and PSP:7/20/10) • Individual #331 (11/09/09 and PSP: 1/6/10) Of the 21 individual records received and reviewed, only 10 (48%) had communication assessments current within the last 12 months, though one of these (Individual #148) was only a brief equipment update. The current assessment for Individual #405 was an update (3/2/10) to a comprehensive baseline evaluation on 2/25/09, while the others were comprehensive baseline assessments. There were 11 individuals (52%) with no current communication assessment, baseline or update, in their personal record. There was no current SLP assessment submitted for Individual #195 since 03/28/05 when an update was completed referencing a baseline evaluation in 1987. This reported that he had no functional verbal expressive skills and that his "prognosis appears good for	

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		maintaining existing communication skills without therapeutic intervention." The update reported that he was "basically non-verbal" with no recommendations or specific training instructions. The Master Plan listed that he was scheduled for a communication system assessment after June 1, 2010." He was identified in the Master Plan with a BSP, though this was not listed in his PSP. Of the 38 assessments submitted and reviewed, there were approximately nine individuals who were reported to have had functional verbal communication. Each of these was an individual who had been admitted to MSSLC in the last 12 months. Each of the current assessments contained a section related to Augmentative/ Alternative Communication and Assistive Technology. These were brief and a number did not report specific findings of actual observation of AAC use or trials over time, and most did not recommend diagnostic therapy to accomplish this. Some examples included: • Individual #218 received a baseline assessment on 6/22/10 that reported he previously had a Cheap Talk (8) on the Go that was not in working order at the time of the assessment. There was no indication as to how long this had been the case. The SLP clinician recommended to discontinue the device and instead recommended use of a Go Talk 9+. She stated that he could access this device independently, but there was no rationale as to why she thought it appropriate to change to this new device rather than ensure that the other was in working order. • Individual #35 received a baseline assessment on 1/18/10. While it was reported that a communication system involving two single switch buttons with voice output was recommended, the specific devices were not described, how he used them was not reported, and the location of the devices was not discussed. • Individual #148's assessment, dated 2/24/10, described that he had been provided a Big Talk device and was able to activate it with his hands. There was no description of the location, his fine motor skills, or how he used it functionally during his every day activities. • Individual #347 received an Augmentative Communication Consultation that indicated he should be provided a Little Step by Step for use in all settings. There was no description of how he used it other than by "depressing the switch." It was also unclear as to how it was to be used functionally throughout his day. As reported above a number of individuals who were nonverbal with significant language deficits had not received a current communication assessment to date.	

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		Standard: All people received a communication screening or assessment within 30 days of admission, readmission, or change in status. In most cases, it appeared that the face-to-face communication assessments for those individuals newly admitted to MSSLC were generally provided within 30 days of their admission, however, there was evidence that the actual written report was completed much later, and this was of significant concern. The assessment should not be considered to be complete unless the actual report is finalized and submitted. For example, Cara Mattson reported that she had "completed" 15 assessments, but was significantly behind on the written documentation. In addition there was reference in the documentation submitted related to assessments for those newly admitted that the reports were not available for a number of those requested because they were still with the dictation service. For example, Individual #336's assessment was not available at the time of the onsite document request by the monitoring team, more than three months later. Individual #203's assessment was not available at the time of the onsite document request by the monitoring team, approximately three months later. There also appeared to be a significant delay in the provision of assessments for others as well due to the dictation service. By report, many of these assessment reports required up to six hours to complete. While the dictation service was implemented to address the staffing shortage and difficulties with completing paperwork in a timely manner, this solution removed the responsibility from the clinicians, but did not appear to have solved the problem of timely completion of paperwork. In Individual #589's PSP dated 12/8/09, it was documented that there had been a referral sent to Speech by the QMRP on 1/13/09 requesting an assessment for a communication device. As of the PSP meeting, this assessment had not been completed. There was no communication information in the assessment portion of the plan. Individual #589 was described as nonverbal and had a PBSP and, as such, would be considered a Priority 1 per the Master Plan. There was no indication that individuals were re-evaluated upon change in status. The MSSLC POI indicated that this was inconsistent due to staffing shortage. **Standard: Communication Assessment addresses:** • **Both verbal and nonverbal skills** • **Expansion of current abilities** • **Development of new skills** • **Whether the individual requires direct or indirect Speech Language services and**	

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		• **The need for further assessment in Augmentative Communication.** The majority of the assessments reviewed (only current assessments were reviewed for these elements) generally addressed both verbal and nonverbal skills. In some cases, there was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish goals and objectives for communication supports and interventions. It was also often not clear as to how effective the current methods used by each individual were within their daily routine. The clinicians reported what system the individual had and that it met his or her needs, but not how it was used and whether or not it was effective. Recommendations for further assessment related to AAC were not noted in any case. In most cases, the assessment addressed expansion of current abilities via some limited communication strategies. There was no evidence that there was a specific effort to expand current skills or develop new ones via specific goals for supports and interventions. There was some limited reference to activity plans for some individuals, but in many cases these were reported to be discontinued. There was only one individual receiving direct speech therapy and this was focused on providing trials with a speech generating/voice output communication device. The goal was that he would "activate SGD with verbal and visual cues, during meaningful activities, 3/5 trials over three consecutive months." By report, as of 7/26/10, he was making progress, though there were only two progress notes submitted. Though the assessment recommended that a voice output device be available to him throughout his day, there was no device issued to him. He only had a Communication Dictionary per the AAC Spreadsheet submitted. There was no evidence of additional therapy to promote skill enhancement or acquisition, or even to provide structured opportunities or trials with a specific device, for other individuals. **Standard: If receiving services, direct or indirect, the individual was provided a comprehensive Speech-language assessment at a frequency that ensured relevance and appropriateness of goals.** Per report of the clinicians, only one individual received direct speech intervention as described above. Individual #216 participated in therapy four times a month with duration of three months. It had been recommended that he receive a re-assessment in one year. The Master Plan provided that each individual with a communication system (appeared to also include the Communication Dictionary) would receive an annual	

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		update and that changes in function would trigger re-assessment as well. These were reported to be inconsistent due to staffing shortages, however. Updates for Individual #405, dated 3/2/10, to a baseline evaluation on 2/25/10 and for Individual #519, dated 5/17/10, to a baseline evaluation on 6/2/09 were the only current updates submitted. **Standard: For persons receiving behavioral supports or interventions, the Facility had a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP.** The initial screening specifically identified those individuals who were non-verbal with behavior plans and not considered to be at high medical risk as the highest priority for assessment. The deadline for assessments of Priority 1 individuals had been moved from 5/31/10 in the initial Master Plan to 7/31/10 in a revised plan submitted. Per staff report at the time of the onsite review, these were not yet completed and another revised completion date was provided as "mid-October." **Standard: Communication programs were integrated into the BSP as indicated.** The only communication plans submitted consisted of the Communication Dictionaries. While these provided extensive information about methods staff could use to interpret and respond to communicative behaviors by individuals to whom they were assigned, these did not appear to be integrated into the PBSP in any way. There was reference to the nurse and dining plans in the Dictionaries, but there was no reference to the PBSP in any of the plans submitted. It could not be determined by reviewing the Communication Dictionaries if the strategies listed were consistent with those outlined in the PBSP. This monitoring team did not review the specific PBSPs to further evaluate this. There was occasional reference to activity plans for communication systems issued to individuals and the PNMP monitoring listed an instructional plan as an element that was monitored on the Speech Equipment Monitoring Sheet by the Speech Assistant. The completed forms submitted were dated for July 2010 only. There were approximately 168 individuals monitored from one to four times during that month. Of those, only 29 had instructional plans listed. Per the monitoring sheets submitted and reviewed, there was evidence that the instructional plans were available for only 14 individuals during 100% of the occasions they were monitored (one individual was only monitored once); two had these plans available 50% of the occasions, (one individual was only monitored once), two had the plans available 50% of the time, five had plans available on only one occasion, and it was documented that the instructional plan was not available on any occasion observed by the monitor during the month of July 2010 for seven others. The following individuals did not have a current communication assessment despite the fact that they each were listed with a PBSP: Individual #589 and Individual #196.	

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		Individual #589, who was identified with a severe communication deficit, had not received a comprehensive communication assessment since 2005. As stated above, this had also been requested by the PST 21 months earlier. Though Individual #196 had received a communication evaluation update on 7/20/09, it did not reference a specific baseline assessment. The Clinical Impression section referred to evaluations in 2001 and 2008, while the PSP stated she had a "Baseline Update Evaluation on 8/11/09." Though it could not be clearly discerned from the documentation reviewed, it appeared that a Baseline Communication Assessment was still indicated. The Master Plan data base indicated that she should have received the assessment prior to 5/31/09. **Standard: Policy existed that outlined assessment schedule and staff responsibilities.** The current state policy referenced a "Communication Master Plan" that was intended to prioritize assessments and services based on need. The assessment plan in use at MSSLC was based on the completed screenings and the resulting rankings based on need for AAC. The timelines outlined in the plan, however, had been remained individuals who had not yet received a completed communication assessment despite the extended deadline established. Per the current system outlined by the clinicians, they planned to complete annual re-assessments for individuals who received direct services or were provided a communication system. This was reported to be inconsistent at this time due to staffing shortages.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	**Standard: Rationales and descriptions of interventions regarding use and benefit from AAC were clearly integrated into the PSP.** As described above there were a number of individuals reviewed without current communication assessments. In many cases, there was little rationale for recommendations made by the clinicians, though some demonstrated this much more effectively than others. The current PSP format did not provide a holistic picture of the individual complete with a description of his or her communication methods and abilities, or of his or her ability to understand what others communicated. The manner in which communication was addressed within that also varied from team to team. Some examples from PSPs included the following: • The description of Individual #196's communication skills was limited to a summary of the communication assessment recommendations and outcome "to participate in activities of daily living" was listed in Action Plan #2 of her PSP dated 9/16/09. The steps listed included only "communication" with the responsible person identified as education and training staff with monthly	Noncompliance

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		progress notes to document her progress. There was no clear statement of what she was to achieve in this area and the SLP had indicated that she had reported in the Update that her "communication skills no longer suggest a potential for positive change." A PSP Addendum on 7/13/10 indicated that her PBSP targeted Self Injurious Behavior and Aggression Toward Others and Uncooperative Behavior. The replacement behavior was "to appropriately communicate likes and dislikes." No one from speech was present at this PST meeting. Clearly the members of the PST were not on the same page with regard to her needs. • The only reference to communication in Individual #486's PSP (7/20/10) was in the General Discussion Record and stated merely that she was non-verbal, and expressed her likes and dislikes via body movements and vocalizations. It was further stated that she had a Communication Dictionary and that English was her preferred language. There was no reference to a communication baseline evaluation dated 7/12/10 (it was stamped as received on 7/21/10 after the PSP meeting). The assessment recommended that she "continue to address switch activation as a part of her plan with specific indications as to the position of the switch to ensure accidental activation to promote learning." There was no mention of the switch in her PSP and speech staff did not attend the meeting. • Individual #431's PSP (4/20/10) referred to a consult completed by Jean Reboli, MS, CCC/SLP on 5/26/09 nearly one year earlier. The PSP directly quoted information from that consult report that indicated that she used a Cheap Talk on the Go device with four icons or messages, but did not indicate what those messages were, nor the function they served for Individual #431. The communication section in the General Discussion Record stated only that she expressed her needs by using gestures and vocalizations and that English was her primary language. There was no evidence of an interim meeting to discuss the findings of a Baseline evaluation completed for Individual #431 on 5/24/10. • The only reference to communication in Individual #435's PSP, dated 10/17/09, was that he "communicates emotions by slapping face when he is upset or frustrated and smiles, holds your hand and gently shakes your hand when he is happy." He had not received a communication assessment since 12/1/05. In that assessment, it was reported that he reached out to grasp his foster grandmother's hand, shook objects to make a sound, and moved his body to music. If he wanted to be left alone he "lightly hit" the person touching him or stiffened his body and screamed. He was not listed with any AAC system, including a Communication Dictionary in the AAC spreadsheet dated 8/18/10. • Individual #438's PSP described his communication skills in the General Discussion Record section of the document. It was stated that he communicated using gestures and limited vocalizations and had a Communication Dictionary. He had not had a baseline communication assessment since 1994 and had an	

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		update to that assessment on 12/27/05. The only support provided to him had been the update. By report, however, he used vocalizations to "manipulate" others, and he responded to his name and to greetings. The clinician stated that he appeared "to display adequate communication skills for his current environment and needs." There were no recommendations or training instructions. His current PSP, dated 12/1/09, had outlined an outcome for him to "participate in activities of daily living to prepare for community living." One of the steps to reach this outcome included "communication" with the responsible person listed as speech and HLT. There was no evidence that an SLP participated in this training outcome. There was reference to a Communication Dictionary. He was not included in the AAC Spreadsheet, dated 8/18/10, for any AAC system. **Standard: The PSP contained information regarding how the person communicated and strategies staff may utilize to enhance communication.** As stated above, the PSP offered very limited descriptions of how an individual communicated with others and offered even more limited instructions as to how staff would best communicate with him or her. The PSPs generally included the communication assessment in part or in full when there was one available. The communication section of the General Discussion Record was limited to a couple of sentences regarding how the individual communicated, but it was not typical to read anything about how staff should communicate as a partner. The Communication Dictionary usually contained this information, but other than mentioning that there was one in some cases, the actual strategies were not addressed in the plan itself. **Standard: AAC devices were portable and functional in a variety of settings.** In general, it appeared that the existing AAC systems were functional. It was not clear, however, that they were used consistently in a variety of settings, and this appeared to be left to the direct support staff and Education and Training staff to implement without sufficient integrated support from the SLPs. As described above, Individual #405 used blinking of his eyes to convey "yes" and "no," however, there was discrepancy as to whether he blinked once or twice for "yes." The solution by the PST was to provide training rather than recommend further assessment to discern which was correct or if he was merely inconsistent. In either case, this should involve the SLP and there was no evidence of this. **Standard: AAC devices were individualized and meaningful to the individual.** In most cases the selection of a device and messages were not typically well-justified in	

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		the assessment. There appeared to be more of a focus on the device and the individual's response to it rather than an assessment of the individual's participation in his or her routine activities to assess where he or she may have a need for getting attention, making a request, or making a choice, for example. These may provide cues for opportunities for communication enhancement that may be overlooked when the assessment occurred only during a clinical sample of behavior. With appropriate staffing, the clinicians would be more readily available for integrated supports and ongoing assessment across settings and environments throughout the PSP year rather than in a defined time period just before the annual meeting. For example, in the case of Individual #498, per his baseline evaluation on 3/23/10, it was reported that he had previously been provided a vibrating pillow and switch because he appeared to respond to the vibration during a consult on 4/16/09. There was absolutely no documentation as to his use of this item in the baseline evaluation over the year, yet it was discontinued at that time with no rationale offered. His PSP did offer some explanation, but none of that information had been addressed in his assessment report by the clinician. It was of concern that this was not identified as a concern until more than a year later and was summarily dismissed rather than investigated for a potential solution with documentation of such. It was reported that he would receive a communication equipment update for his Communication Dictionary prior to his annual staffing in 2011. In the case of Individual #35, two single switch buttons with voice output were selected as a communication system, but there was no rationale as to why these were selected. No suggestions as to how they would be incorporated into his daily routine other than that modeling, verbal, gestural and/or physical prompts would be necessary to encourage him to use the switches independently, were offered. **Standard: Staff were trained in the use of the AAC.** Staff received a one hour general training related to alternative communication in new employee orientation, but further staff training in the area of communication strategies by speech staff was limited due to the many other responsibilities of the staff and if provided, was often provided by the Speech Assistant. The communication strategies listed in the assessments appeared to be useful, though as these generally did not get integrated into the PSP, it was not clear how that valuable information was shared with direct support staff who would need it. These strategies were also not included on the PNMP. As described above, the instruction sheets were intended to provide information to staff	

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		related to AAC systems for specific individuals were most often not available per the findings of communication equipment monitoring. In many cases the only information on the PNMP was that an individual was verbal or that the reader should refer to the Communication Dictionary. Based on review of the approximately 223 PNMPs submitted, they did not consistently list the communication equipment under the assistive equipment section of the plan, though the reader was at times referred to the instructions for augmentative devices, such as for Individual #3. "Augmentative Device" was also listed for Individual #46, Individual #148, Individual #356, Individual #222, Individual #553 (though no device was listed under assistive equipment), Individual #405, Individual #389, Individual #399, Individual #56, Individual #122, Individual #584, Individual #515, Individual #474, and Individual #4, but it was unknown what device they were to use. The reader was referred to instructions. There was no reference to communication on the PNMP for Individual #155. The PNMP stated "N/A" related to communication for Individual #82 and was left blank for Individual #226 and Individual #289. More extensive instructions were offered in the PNMP for Individual #562. **Standard: Communication strategies/devices were implemented and used.** Most staff were observed to be communicative and interactive with individuals during a variety of activities, including day programming activities and, in some cases, mealtimes, however, there was little interaction noted during the in-between times, such as before meals when most individuals were observed to be sitting around and waiting. Much of the interaction observed was utilitarian to a specific task with little other interactions that were meaningful. Devices noted in the day programs were not always placed where the individual had ready access to the device and, as a result, spontaneous opportunities to use the system and seek a response from others, or reinforcement of communication efforts. were limited. The monitoring team also observed that staff showed very little interaction with the individuals during an evening meal and had not adhered to the strategies outlined in the dining plans. This was immediately reported to the Unit Manager and steps were implemented to address the issues, however, it was of concern that it would be likely that the safety issues would be addressed effectively, but not the issues related to communication and interaction. **Standard: General AAC devices were available in common areas.**	

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		A number of community devices were available, but not observed to be used during the onsite review by the monitor's team.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	**Standard: A monitoring system was in place that: tracked the presence of ACC; working condition of AAC; the implementation of the system; and effectiveness of the system.** A system using the Speech Equipment Monitoring Sheet was implemented by the Speech Assistant. Approximately 143 completed sheets were submitted reflecting monitoring during the month of July 2010 for 168 individuals. Over 50% of the sheets submitted recorded a "no" for one or more indicators for one or more individuals on one or more observations dates. These indicators included availability of AAC, working order of equipment, instruction sheets, and inclusion on the PNMP. Effectiveness of the AAC system was not monitored by the Speech Assistant and, as evidenced by some of the documentation, was also not monitored by SLPs either. **Standard: Monitoring covered the use of the AAC during all aspects of the person's daily life in and outside of the home.** Monitoring of AAC was conducted most often in the homes rather than across settings per the monitoring sheets submitted. **Standard: Validation checks were built into the monitoring process and conducted by the plan's author.** There was no routine system to validate the continued competency of monitors at MSSLC at the time of this onsite review by the monitoring team.	Noncompliance

Recommendations:

1. Examine current efforts to recruit new speech clinicians. The existing SLPs cannot possibly meet all the needs of the individuals who live at MSSLC and the department is at great risk for problems with retention as well as with meeting the requirements of the Settlement Agreement. There was some question as to the knowledge and skills of at least one of the existing staff and this placed the department in jeopardy if this is not addressed in an effective and timely manner.

2. The plan for timelines of completion of assessments should be clarified so that all SLPs and the PSTs know when an individual is due for assessment. There were inconsistencies in the Master Plan as to how individuals were prioritized and it was not clear as to the actual status of the completion of assessments.

3. The clinicians must carefully review their current system of assessment, report writing, and other related activities. Given the current staff shortage and the high identified need for individuals living at MSSLC, the SLPs must figure out how to work smarter and more efficiently. It is not a cost effective process to take six hours (as reported) to complete the assessments and ensure that the critical supports can be effectively provided for implementation of AAC systems integrated in a meaningful and functional manner as well as providing modeling and coaching for staff to build effective capacity and understanding.

4. Many of the current assessments lacked adequate justification for the recommendations for specific AAC as well as for recommendations that communication supports (other than the Communication Dictionary) were not indicated. This must be addressed for the assessments not yet completed, but must be also addressed for those assessments already done. This is a key element to a comprehensive assessment that meets generally accepted professional standard of care.

5. When an update is completed subsequent to a strong baseline assessment, reference to the comprehensive assessment should be made in the update and the comprehensive assessment should not be purged until such time a new comprehensive assessment is completed. This is critical to ensure continuity and to permit tracking of decision making and clinical reasoning by SLPs. This will be particularly important as new staff are added to the department or when the assessment is completed by a different therapist during a previous year.

6. Many recommendations appeared to be left to the PST for the development and implementation of plans. It is critical that SLPs be involved at least in a consultative model to ensure that the plans, materials and implementation are within the scope of the individual's abilities and/or promote enhancement and skill development, as well as modeling and coaching for staff. SLPs should be utilized in the development of instructional plans in a variety of settings to ensure that they are individualized with regard to the communication strategies incorporated into these plans. Communication goals can and should be addressed across the full gamut of training objective programming.

7. The focus of monitoring for AAC systems should address effectiveness and implementation versus only availability and condition. This will require professional staff to conduct more frequent and thorough monitoring in addition to that conducted by the Speech Assistant.

8. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSP.

9. Ensure improved integration of assessment and methodology for communication-related plans both formal and informal, including sign language, picture exchange, assistive technology, and other AAC systems to include speech clinicians, psychology, and other staff responsible for program development. Selection should be bimodal, meaning that AAC should utilize the individual's full communication capabilities, including residual speech or vocalizations, gestures, signs, and communication aides. These should be based on what best matches each individual's skills and functional needs across environments and settings. The integration of effective communication strategies ensures that active treatment is engaging and more meaningful to the individual.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Personal Support Plans for: • Individual #422, Individual #463, Individual #235, Individual #98, Individual #183, Individual #89, Individual #448, Individual #443, Individual #488, Individual #372, Individual #481, Individual #523, Individual #312, Individual #241, Individual #211, o Specific Program Objectives (SPOs) for: • Individual #372, Individual #433, Individual #89, Individual #183, Individual #488, Individual #398, Individual #535, Individual #448, Individual #283, Individual #281, Individual #570, Individual #463, Individual #43, Individual #293, Individual #349, Individual #545, Individual #550, Individual #599, Individual 579, Individual #455, Individual #159 o Graphs summarizing SPO Progress for: • Individual #463, Individual #331, Individual #159, Individual #477 o Monthly Data Card/Progress Note for: • Individual #183, Individual #535, Individual #433, Individual #89, Individual #398, Individual #488, Individual #448 o Six months of mater teachers notes for: • Individual #183, Individual #535, Individual #89, Individual #433, Individual #448, Individual #398, Individual #488 o Positive Adaptive Learning Survey (PALS) for: • Individual #448 o Education and Training Master Teacher Training Manual (dated 8/10) <u>Interviews and Meetings Held</u>: o Don Morton, Director of Education /Training o Tammy McCulloch, Life Skills SAM-HIP Coordinator o Norvell Starling, MSSLC liaison to MISD <u>Observations Conducted</u>: o Personal Focus Worksheet (PFW) Meeting for: • Individual Discussed: - Individual #581 • Staff Present: - Elisa Gandy, RN; Kerry Bullard, Community Living; Jace Floyd, Master Teacher; Melinda Fitch, QMRP; Brenda Ridge, Staffing Coordinator; Chris Christensen,

	Psychologist; Deborah Grimmett, Supervising Psychologist; Patsy Green, DCP o All MISD classrooms on MSSLC campus o Observations occurred in various day programs and residences at MSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training), and • Implementation of behavior support plans
	Facility Self-Assessment: MSSLC's Plan of Improvement (POI) indicated that all items were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings of noncompliance in all areas, except that the monitoring team noted, as detailed in this section of the report, compliance with several subsections related to all three items of this provision.
	Summary of Monitor's Assessment: This provision of the Settlement Agreement incorporates a wide variety of aspects of programming including skill acquisition, engagement in activities, and staff training. To assess compliance with this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. Although no provisions of the Settlement Agreement were found to be in substantial compliance, the facility was making good progress in several areas including an improvement of the procedures used to teach new skills, the addition of graphing of specific program objectives (SPOs), and new treatment integrity and engagement tools. Many of these improvements were too new to be fully evaluated by the monitoring team and will be reviewed in future tours. Progress was also noted in the public school educational services provided.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at MSSLC. Although much work has been done to address this settlement item, more work needs to be done to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision. As a result, this provision is rated as being in noncompliance.	Noncompliance

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	training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	<u>Skill Acquisition Programming</u> Personal Support Plans (PSPs) reviewed indicated that all individuals at MSSLC had multiple skill acquisition plans. Skill acquisition plans at MSSLC consisted of: • Training objectives, referred to as specific program objectives (SPOs) that were written and monitored by master teachers and primarily implemented by education and training instructors. • Replacement and medical desensitization programs written and monitored by the psychology department. These plans were implemented by DCPs. • Habilitation programs, written and monitored by specific rehabilitation professionals (e.g., physical therapists, speech language pathologists). The habilitation plans are discussed in sections O and R and, therefore, will not be discussed further here. Medical desensitization programs were recently begun to be developed and monitored by the psychology staff at MSSLC. These skill acquisition plans teach individuals to tolerate medical interventions (e.g., dental exams), and can result in a decrease in the use of sedating pre-exam medication. Two of these plans (for Individual #283 and Individual #516) were reviewed by the monitoring team. As recommended in the baseline report, the plans were written by psychologists and were incorporated into the general training objective methodology for all SPOs. As such, they were subject to the same strengths and weaknesses discussed below for all SPOs at the facility. They did, however, represent an improvement from the baseline visit. Outcome data (including the use of sedating medications) from the desensitization plans will be reviewed in more detail in future site visits. Additionally, the psychology department was writing replacement plans that were included in each individual's PBSP, although none of the PBSPs reviewed included specific instructions for how to train replacement behaviors. (See K5 for a more detailed description.) It is recommended that replacement behavior training procedures, like those for the desensitization plans, be incorporated into the general training methodology, and conform to the standards of all skill acquisition programs listed below. An important component of an effective skill acquisition plan is that it should be based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, or psychological assessment. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need.	

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		Conversations with the Education/Training Director, Life Skills SAM-HIP Coordinator, and observation of a Personal Focus Meeting, all indicated that the facility did attempt to incorporate preferences and needs in the development of each individual's SPOs. Additionally some the SPOs reviewed included a rationale for why that particular SPO was chosen. For example: • Individual #599's SPO for purchasing items from the vending machine stated Individual #599 "...works at the Client Employment Center… He likes to buy snacks… so if he can learn to use the coin-operated machines…" he can independently get his own snacks. In reviewing 15 PSPs, however, it was not consistently documented that SPOs were developed to address needs identified in each individual's assessments. It is recommended that the facility more clearly document how SPOs are based on individual needs and preference. Once developed, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology The SPOs at MSSLC consistently included most of these components, such as task analysis, behavioral objectives, operational definitions, and the use of consequences for correct responses. During the baseline review, the monitoring team was most impressed by the consistent review of SPO progress and monthly notes describing progress and data-based action for the next month. Since the baseline review, the facility had improved its review of SPO progress by including the graphing of outcome data to further enhance their decision making. Additionally, MSSLC has begun to modify its SPO format to better address the above components, and since the last review, had expanded its training procedures to include both forward and backward conditioning and the	

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		fading of prompts. Finally, the facility was beginning to collect integrity data to ensure that SPOs were implemented as written. The monitoring team recognizes the considerable efforts by the facility to achieve substantial compliance with this provision item. Their commitment to achieving compliance was reflected by the Life Skills SAM-HIP Coordinator volunteering to take the coursework to become a BCBA, in large part, to better learn the most effective ways to write and monitor SPOs. In addition to the recommendations presented in this provision, the facility should focus future efforts on further developing some of the components above that were not apparent in the review of the SPOs. Those components included the use of specific consequences for incorrect responses, the use of relevant discriminative stimuli, inclusion of the documentation methodology, and a plan for maintenance and generalization of acquired skills. Finally, although all of the SPOs reviewed indicated that individuals should be reinforced and encouraged following a correct response, specific consequences for correct responses (e.g., positive reinforcers) were not consistently included in the plans. <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at MSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals in the day programs and homes at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed in the table below. The monitoring team was encouraged by the overall quantity of age appropriate and typical activities at MSSLC. Consequently, in several homes visited, many or most of the individuals were out of the homes, engaging in activities (e.g., playing basketball, at the gym, attending religious services). Many of the remaining individuals were often engaged in other typical activities, such as listening to music, talking to friends, watching television, or playing video games. In the homes where the individuals did not possess the skills to readily engage in independent activities, the ability to maintain individuals' attention and participation in the activities varied widely across staff and homes. The	

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		table below documents this variability across settings. The average engagement level across the facility was 51%, somewhat less than that observed during the baseline tour (i.e., 59%). An engagement level of 75% is a typical target in a facility like MSSLC, indicating that the engagement of the individuals at MSSLC continued to have room to improve. The facility recently developed a methodology to regularly collect engagement data in each setting. The monitoring team was encouraged by the introduction of this tool, and will review it and subsequent engagement data on future tours to the facility. It is recommended that MSSLC now establish and track specific engagement goals in each home and day program site. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
W8	1/5	4:5
W8	1/3	3:3
W7	0/1	0:1
W7	3/8	3:8
S7	4/7	3:7
S7	1/2	0:2
L1	4/5	1:5
L2	3/6	2:6
L3	6/6	2:6
L4	2/4	2:4
L5	3/6	3:6
L6	3/3	2:3
S1	3/8	4:8
S1	2/8	4:8
S2	1 /1	1:1
S2	2/4	4:4
S3	4/5	3:5
S4	1/2	1:2
B1	4/8	3:8
B4	3/7	2:7
B3	0/3	1:3
B3	0/7	2:7
B6	0/7	3:7
B7 and B8 (common area)	5/10	3:10

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W6	2/2	2:2
W5	1/3	2:3
W4	4/6	2:6
W3	2/2	2:2
W2	2/6	3:6
W1	6/6	1:6
M1 and M2 (common area)	2/5	1:5
M8	4/25	6:25
M5	1/5	1:5
M6	2/3	2:3
M6	4/6	3:6
M6	1/3	2:3
STEP Center	1/2	1:2
STEP Center	3/4	3:4
STEP Center	4/6	3:6

Educational Services

Since the baseline monitoring tour, a number of positive changes had occurred in the working relationship between MISD and MSSLC. First, a new/acting superintendent of MISD was appointed and one of his goals was to provide an appropriate education to MSSLC residents that met all state and federal requirements. This appeared to be supported by the school board as well as the general community. This set the occasion for better communication between the facility and school and for the initiation of joint projects, such as a new vocational program that was in development. Second, the security protocols were changed to a more appropriate level of supervision at the MSSLC on campus school building. The new system (one security officer instead of two police officers) appeared to reduce the likelihood of escalated interactions between security personnel and students. Third, a plan was in place for students to work their way towards more and more opportunities within the public school campus. This also appeared to be reasonable, motivating, and a way of increasing the likelihood of creating safe and engaging classroom environments. The MSSLC liaison reported that most students were motivated to go to what they called "downtown" for school. Fourth, on campus classroom sizes were reduced. Each of the three classrooms had an MISD special education teacher, one aide, a behavior specialist, and any one-to-one staffing (the latter was provided by MSSLC).

There was a marked difference in the level of student engagement, participation, and activity compared to the observations conducted during the baseline tour. Group topics in the classrooms included history, fiction, and careers. Thirty-one students were

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		present out of a total of 43. It was unknown to the monitoring team as to why the other 12 students were not present during the observation. The MSSLC liaison reported that QMRPs were active participants in the school district ARD/IEP process. Overall, the monitoring team was pleased to see the progress that had occurred in the educational programming and looks forward to looking more deeply at educational objectives and student performance during subsequent tours. The monitoring team learned that MSSLC students received only approximately four weeks of summer school, leaving them out of school for an additional eight or so weeks. The facility should ensure that students are receiving an appropriate amount of educational services across the year.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	MSSLC conducted annual assessments of preference, strengths, skills, and needs. As discussed in S1, however, how this information impacted the type of instructional programming offered to each individual at the facility was not consistently documented in the PSP. Therefore, this item was rated as being in noncompliance. It is suggested that the facility incorporate the results from multiple assessments and evaluations (i.e., in addition to the PALS) to choose individual skills to be trained, and that this process be more clearly documented in the PSP. Additionally, while the PSP attempted to identify preferences, no evidence of systematic preference and reinforcement assessments were found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	Noncompliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services	The facility was progressing on this provision item. Several components of this item, however, had only recently been developed (or were in process of being fully developed), and require additional review. Therefore, this item was rated as being in noncompliance.	Noncompliance

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	and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	The monitoring team observed the implementation of SPOs in several day programs and homes during the onsite tour to evaluate if SPOs were implemented as written. Additionally, SPO data sheets were also reviewed to evaluate if data were completed as scheduled. The monitoring team observed two individuals working on SPOs (Individual #399, working on "making choices," conducted by an Education and Training instructor, and Individual #148, working on "applying lotion," conducted by a master teacher). The implementation of both SPOs appeared consistent with the plan, data were collected, and the staff were able to articulate the SPO and the rationale for its use. Review of compliance with the schedule of implementation was difficult to evaluate because the schedule of implementation was not clearly specified. It is recommended that the schedule of implementation of SPOs be specified so that supervisors can evaluate if a sufficient number of training trials occurred. The skill acquisition plans at MSSLC were clearly practical and functional for some individuals (e.g., teaching Individual #545 to open a banking account), however, some individual's appeared to have similar goals (e.g., using the vending machine). Further, as discussed in S1, the rationale for the selection of SPOs was not consistently documented. Reviews of SPO data revealed that skill acquisition plans were producing meaningful behavior change for many individuals (e.g., self-administration of medication for Individual #463), but not for others (e.g., independent living skills for Individual #372). As mentioned in S1 and in the baseline report, a strength of MSSLC's skill acquisition programming was the tracking of individual progress, and the data-based modifications of SPOs based on completion of goals, or absence of progress. The following examples were typical: • Individual #159 was not progressing in her activities of daily living SPO. The master teacher reviewed the outcome data and modified the plan to allow Individual #159 more time to complete the activity. • The master teacher noted that data were not recorded on two SPOs for Individual #477, and inserviced the instructor in the data collection methodology. The facility recently improved the monitoring of plans by added the graphing of SPO data to enhance decision making. Additionally, MSSLC recently introduced integrity measures to ensure that SPOs were implemented as written. These measures were continuing to be developed and will be reviewed in more detail at the next onsite tour.	
	(b) Include to the degree practicable training opportunities in community	Many individuals at MSSLC enjoyed various recreational activities in the community. It was not clear, however, if these community activities were developed to address specific individuals' needs for services or preference. Therefore, this item was rated as being in	Noncompliance

#	Provision	Assessment of Status	Compliance
	settings.	noncompliance. At the time of the onsite tour, 24 individuals at MSSLC worked in the community. This was down from 36 during the baseline review. Interviews with staff indicated that the primary reason for the decrease in community employment was do the economic recession. Additionally, 11 individuals participated in enclave work; a program where individuals were training to work in the community. Subsequent tours to MSSLC will further evaluate the training individuals receive in the community in order to assess compliance with this provision item.	

Recommendations:

1. It is recommended that replacement behavior training procedures, like those for the desensitization plans, be incorporated into the general training methodology, and conform to the standards of all other skill acquisition programs at the facility.
2. It is recommended that the facility more clearly document how SPOs are based on individual needs and preference.
3. SPOs should include the use of relevant discriminative stimuli and plans for the maintenance and generalization of acquired skills.
4. Include specific consequences (beyond praise) for correct responses.
5. The facility should establish and track specific engagement goals in each home and day program site.
6. It is recommended that the schedule of implementation of SPOs be specified so that supervisors can evaluate if a sufficient number of training trials occurred.
7. The facility should ensure that each individual is provided with training in the community that appropriately addresses his or her needs and preferences.
8. The facility should continue to expand the number of individuals receiving training in the community.
9. Assess whether each student is provided with an appropriate duration of educational services across the year.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and five attachments (exhibits) o DADS Promoting Independence Advisory Committee reports, January 2010, April 2010, July 2010 o Draft of new/revised MSSLC Most Integrated Setting and the Community Living Process Policy, numbered Client Management-12, dated 9/10/10. o MSSLC POI, updated 8/26/10 o MSSLC POI Supplement, 8/18/10 o MSSLC APC Department Settlement Agreement Presentation Book o Summary sheet from opening presentation made to the monitoring team, 9/13/10 o MSSLC Mission Statement o Draft of job description paragraph for new transition monitor position o List of individuals who were referred for placement since 1/1/10 (44 individuals) o List of individuals who requested placement, but were not referred (40 individuals) o List of individuals who have moved to the community since 1/1/10 (63 individuals), and an updated document that listed 67 individuals. o List of individuals discharged under alternative discharge process since 1/1/10 (20 individuals, however, most of these individuals were discharged following 120- or 90-day evaluations and were never admitted, therefore the processes for alternate discharge did not apply) o Discharge packets of information for all individuals discharged under the process for alternate discharges (four individuals) o List of alleged offenders through 8/20/10 (162 individuals) o Description of how the facility assesses an individual for placement o List of all individuals at MSSLC and whether or not each was referred for placement, since 7/1/09 (the list did not indicate the reason for the individual not being referred) o Two data sheets showing individual participation on tours of community providers, 9/9/10 and 9/10/10 o List of individuals who have had a CLDP developed since 1/1/10 (65 individuals) o List of required/typical assessments required for the CLDP o Instructions for staff going on community tours with individuals o Blank questionnaire for a phone survey of providers who were serving an individual who moved from MSSLC over the past six months. o Training agenda and materials for LOD and CLDP training at MSSLC by Donnie Wilson, 7/22-23/10, and staff sign-in sheets o Flyer for provider fair and sign-in sheets o Brochure for Ruth Marie's Country Home, provider agency

	o Barrier report, dated 8/19/10 o DADS central office reviews and comments on 24 CLDPs o CLOIP or Permanency Planning Worksheets for: • Individual #129, Individual #383, Individual #232, Individual #248 o PSPs for: • Individual #481, Individual #211, Individual #241, Individual #312, Individual #422, Individual #523, Individual #426, Individual #341, Individual #162, Individual #179, Individual #183, Individual #89, Individual #448, Individual #433, Individual #488, Individual #372, Individual #463, Individual #235, Individual #98, Individual #358, Individual #115, Individual #570, Individual #248, Individual #509, Individual #77, Individual #400, Individual #407, Individual #49, Individual #541, Individual #257, Individual #449, Individual #100, Individual #221, Individual #500, Individual #597, Individual #140, Individual #229, Individual #370, Individual #589, Individual #475, Individual #176, Individual #236, Individual #22, Individual #386, Individual #243, Individual #416, Individual #530, Individual #31, Individual #48, Individual #175, Individual #11, Individual #206, Individual #446, Individual #467, Individual #123, Individual #47, Individual #464, Individual #136, Individual #84, Individual #461, Individual #492, Individual #2, Individual #125, Individual #453, Individual #498, Individual #231 o CLDPs for: • Individual #241 (Draft), Individual #597, Individual #140, Individual #248, Individual #229, Individual #115, Individual #370, Individual #589, Individual #475, Individual #176, Individual #236, Individual #22, Individual #386, Individual #243, Individual #416, Individual #530, Individual #31, Individual #48, Individual #175, Individual #358, Individual #11, Individual #206, Individual #446, Individual #467, Individual #123, Individual #47, Individual #464, Individual #136, Individual #84, Individual #461, Individual #492, Individual #2, Individual #125, Individual #453, Individual #498, Individual #231 o Post move monitoring checklists for: • Individual #597, Individual #248, Individual #229, Individual #115, Individual #370, Individual #589, Individual #475, Individual #176, Individual #236, Individual #22, Individual #386, Individual #243, Individual #416, Individual #530, Individual #31, Individual #175, Individual #358, Individual #206, Individual #467, Individual #123, Individual #47, Individual #464, Individual #136, Individual #84, Individual #461, Individual #492, Individual #2, Individual #125, Individual #453, Individual #231 <u>Interviews and Meetings Held</u>: o Alynn Mitchell, Admissions and Placement Coordinator o Sarah Hewitt, Post-Move Monitor o Lloydette Harris, Facility Rights Officer o Dr. William Lowry, Facility Director o Brenda Shoemake, Assistant Director for Programs

	o Donnie Wilson, DADS Central Office Continuity of Services Coordinator o Joseph Yoon, CLOIP worker from local Heart of Texas MHMR, the local MRA, and Melissa Guerra an assistant CLOIP worker from the same MRA o Dr. James Simpson, owner, and Gail Champagne, vice president, Ruth Marie's Country Homes o Meeting to discuss the Texas systems regarding placements under criminal and family codes, with Kristen Huff, DADS attorney (via phone), Charlotte Kimmell, Director of Psychology, Alynn Mitchell, APC, Lorri Haden, DADS attorney, and Mark Dennis, Program Compliance Coordinator o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: o PSP Meeting for: • Individual #483, Individual #37, Individual #378 o Community group home visit, post-move monitoring for • Individual #597 o MSSLC Self-advocacy meeting o Many residences and day programs at MSSLC
	Facility Self-Assessment: The facility's self-assessment, its POI, for section T indicated that all items were in noncompliance. The comment for a great many items was "8/17/10-The new policy for Most Integrated Setting and the Community Living Process is being reviewed and waiting for approval from management." Other items had comments referring to the development of other policies, that data were being collected, or that the facility was awaiting direction from state office. The POI did not indicate that the facility looked at any of the PSPs, LODs, optimistic vision statements, CLDPs, or post-move monitoring forms to make a determination of their own substantial compliance or noncompliance. Given the many upcoming changes to most integrated setting and community placement processes that are anticipated to occur at MSSLC over the next few months, it is hoped that the facility will engage in specific activities to self-assess the status of its performance for this provision and all of its components. This will probably involve monitoring, sampling, and providing feedback to PSTs, post-move monitors, and facility management. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the self-assessment's findings of noncompliance in all areas, except that the monitoring team noted substantial compliance in a few subsections related to some components of the CLDP process (e.g., obtaining of signatures, submission of assessments to the community provider). The monitoring team's review was based upon observation, interview, and review of a sample of documents. The facility will need to do much of the same in order to conduct an adequate self-assessment.

	Summary of Monitor's Assessment: Overall, MSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. This provision, however, is rated as being in noncompliance due to the additional tasks and activities that are required by the provision, and improvements to a number of activities, as are detailed below in this section of the report. Further, the monitoring team learned that updates to the DADS policy and procedures for most integrated setting practices were forthcoming. Overall, MSSLC continued to place many individuals in the community. Approximately 100 individuals had been placed in the past year and facility staff were proud of this accomplishment. Moreover, individuals across the campus spoke about wanting to transition to the community. MSSLC maintained an active admissions and placement department. Given the number of transitions, not all work met deadlines (e.g., post move monitoring visits) and not all work was done as thoroughly as it should have been (e.g. CLDP contents). Nevertheless, the staff were knowledgeable and committed to making successful placements and improving their processes. Since the baseline tour, some activities had been directed towards reviewing the CLDPs of individuals who had transitioned over the past six months as well as improving the list of essential and nonessential supports in each CLDP. More work was being done on these areas, but little improvement was observed. Other aspects of this provision were not yet in place in a manner to meet the requirements of this provision, including determining the supports, needs, and preferences of individuals and the characteristics of settings that would support their successful transition and ongoing lifestyle in the most integrated setting appropriate to their needs (i.e., part of the PSP process), determining and addressing barriers and obstacles to placement, and providing individuals with appropriate exposure to community options (e.g., tours). The CLOIP was implemented for every individual reviewed. As indicated below, it should not be considered an assessment for placement, and further work will need to be done to create an assessment for each individual. Post move monitoring was occurring. It was being done by a variety of facility and non-facility staff. Variability in the thoroughness of completion of post move monitoring was found and described below. There continued to need to be more detailed descriptions of essential and nonessential supports so that they could be observed and so that the post move monitors would know what was required to indicate evidence of the presence of the support. The facility recently appointed a new facilitator of the self-advocacy group and meetings were recently re-instated. This will provide the opportunity to add to the content of the self-advocacy group meetings to include community placement, decision-making, and problem solving as regular topics for discussion.

	Some individuals were discharged according to provision T4 who did not appear to meet any of the criteria. This will need to be reviewed by the facility and corrected if need be. Modifications were recommended for improvements to the CLDP, the CLDP process, determination of essential and nonessential supports, and contents of the community placement report.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	MSSLC and the state engaged in extensive activities to encourage and assist individuals to move to the most integrated setting. MSSLC activities to encourage and assist individuals to move to the most integrated setting were, as required, not opposed by the individual or the individual's LAR, and appeared to be made by taking into account the statutory authority of the state, and the needs of others with developmental disabilities. Upon arrival for the onsite tour, the monitoring team was presented with a packet of information about the facility as was done during the baseline tour. The cover page stated, "Our center is in the business of producing successful community placements by providing each individual with the opportunity to obtain skills and supports necessary to make a successful transition into an integrated placement in the community." Indeed, this perspective continued to be seen throughout the facility and was evident in the various discussions, meetings, and observations conducted by monitoring team members during the onsite tour. This was an impressive effort and, as a result, the facility reported a large number of transitions. Some details are below: • 100 community placements had occurred in FY 10 (through August 2010). • 89 individuals residing at MSSLC had been referred for placement and were at various stages in the placement process. • 44 of these 89 had been referred for placement since 1/1/10, the placements for 35 of these 44 were still in process. • 81 individuals were admitted to MSSLC from September 2009 through August 2010. • All alleged offenders were required to receive a risk assessment prior to being referred for placement. It was clear that MSSLC continued to take the Settlement Agreement provision requirements for most integrated setting practices very seriously and, as a result, many individuals had the opportunity to pursue and move into placements in the community. Throughout the onsite tour, monitoring team members met and spoke with individuals who were excited about their upcoming moves to the community. For example,	Noncompliance

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		Individual #140 on the Longhorn Unit and Individual #18 at the Whiterock Unit spoke very positively about their upcoming moves to group homes or to live with their family members again. Moreover, many of the individuals observed by the monitoring team during the baseline tour had since moved to the community. During the week of the onsite tour, the monitoring team met with facility staff and DADS staff to discuss and learn about the state's systems for admission and placement for individuals placed under the state's criminal and/or family codes. The monitoring team appreciated learning about the state systems, and the facility's role, regarding determination of mental retardation, competency for trial (called fitness to proceed for juveniles), commitment orders, charges, treatment procedures and interventions, and placement challenges. This provision item, however, cannot be considered to be in substantial compliance due to the need for further actions and activities to occur, including the implementation of revised policies for PSP development and CLDP development and implementation, consideration of the opinions of professionals regarding appropriateness of community placement for each individual (i.e., ensuring that recommendations of facility professionals are considered independently from LAR preferences), and the monitoring and management of important referral-related outcome information. In addition, little change or progress had occurred since the baseline monitoring tour regarding: • determination of needed supports • identification of obstacles • identification of essential and nonessential supports • objective determination of the presence or absence of essential and nonessential supports following community placement. The lack of progress was especially troubling given the challenging nature of the problems presented by many of the individuals who were placed, or who were referred for placement, including histories of serious behavioral and psychiatric disorders. The monitoring team, however, learned about many changes that were in the works at both the facility and state levels regarding PSP processes, CLDP contents, determination of evaluation of essential and nonessential supports, and training of all facility staff and departments in the community referral and placement process. Alynn Mitchell was the Admissions and Placement Coordinator (APC). She was assisted by Sarah Hewitt, the facility's Post-Move Monitor (PMM). The monitoring team had the	

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		opportunity to meet with both of these professionals. They were knowledgeable about the placement process and experienced with local providers and families. They described some upcoming changes to the state and facility policies and practices regarding most integrated setting practices. One of the changes was that Ms. Mitchell expected to add three transition monitor positions to her staff. The plan was for these staff to shepherd through all referrals, assisting the individuals and their PSTs to keep the process moving along. These staff will also do the post move monitoring for the facility. It is likely that these new staff, if trained properly, can play a role in ensuring that the CLDP process is as thorough as it needs to be, including the review of all assessments and reports so that all appropriate essential and nonessential needs get included in the CLDP. The monitoring team also had the opportunity to meet with Dr. William Lowry, facility director, and Brenda Shoemake, Assistant Director of Programs, to discuss a number of topics, including the baseline report review of CLDPs and the facility's response to the recommendations over the past few months (more detail is provided below in section T1e). Both administrators indicated a desire to ensure that CLDP and transition planning were done correctly, conservatively, and safely. During the week of the onsite tour, the monitoring team also met with Donnie Wilson, the DADS central office Continuity of Services Coordinator. He had statewide responsibility for implementation of most integrated setting practices. He described a number of activities that were in place, or going to be in place, to revise and improve the LOD and CLDP processes Overall, funding did not appear to be an obstacle to any individual's transition. The APC reported that there were no instances of a placement being delayed or prevented due to lack of funding and that there were plenty of slots available to individuals at MSSLC.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. This provision item was found to be in noncompliance due to upcoming changes in the state and facility policies regarding most integrated setting practices, and the comments made below regarding all subsections of this provision T1b. The state developed a policy regarding most integrated setting practices and it addressed this provision item. It was numbered 018.1 and was dated 3/31/10. This policy was updated from a previous version. The updates were relatively minor, primarily regarding methods of reporting facility information to the state central office. The purpose of the policy was stated in the first paragraph and noted that it was to encourage	Noncompliance

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		and assist individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L.C. The policy stated that it applied to all DADS SSLCs and numerous definitions were included. The policy also detailed procedures for assisting individuals with movement to the most integrated setting, identifying needed supports and services to ensure successful transition, procedures for identifying obstacles for movement, and post-move monitoring procedures. The policy also described procedures to meet other items in this provision of the Settlement Agreement. The policy called for encouraging individuals to move to the most integrated setting consistent with the determination of professionals on the individual's PST that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. The policy provided detail on the types of meetings, documents, and processes that were to occur. The policy did not specifically note that placement must take into consideration the statutory authority of the state, the resources available to the state, and the needs of others with developmental disabilities. The policy did, however, note that part of its purpose was to bring the state into accordance with the Olmstead decision. That decision specifically referred to these considerations and, therefore, these aspects did not need to be identified specifically in the policy. The APC reported that MSSLC had adopted the state policy and was working under the policy, however, a number of revisions to policy and practice were in process and being updated. The revised policies were likely to include more involvement of the PST in the referral process and the post-referral process, PST involvement in visits to community providers, a review of post-move monitoring with the PST, and extra assurances and procedures regarding the determination of essential and nonessential supports in the CLDP. In addition, the APC had developed a facility policy that combined some of the other policies noted in the baseline report (as recommended in the baseline report). This new policy was called "Most Integrated Setting and the Community Living Process." It was in the policies and procedures manual labeled as Client Management-12, and was dated 9/10/10. It was in draft format and was being reviewed by facility management. Following that review, the facility should obtain some type of documentation of approval of this policy from the DADS central office discipline head. Also, future revisions of facility policy might focus on only including additions to, and differences from, the state policy, rather than including repetitions of state policy. In this way, future updates to state policy might not require a revision to also be made to facility policy.	

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		The monitoring team also looked to see if the policies and procedures were being implemented consistently. MSSLC staff were working towards implementing the DADS policy #018.1 and expected to modify facility practice based upon upcoming policy updates. As noted throughout the remainder of this section of the report, many of the procedures and practices were being implemented, however, not in a thorough manner that met the requirements of the Settlement Agreement.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	This provision item was found to be in noncompliance based upon the need for implementation of a process to adequately identify the protections, services, and supports that need to be provided to the individual, as well as the identification of obstacles to movement to the most integrated setting and a plan to overcome those obstacles. The monitoring team was informed that new policies and procedures were being developed by DADS regarding the PSP process. These policies and procedures were to be taught to QMRPs sometime over the next few months and then implemented at each facility. Sixty-six annual PSPs were reviewed, for the individuals listed in the Documents Reviewed list at the beginning of this section of the report. Thirty-one of these were individuals chosen for review by monitoring team members. The other 35 were individuals who had moved within the previous 90 days of the onsite tour. The total sample included individuals representing different levels of referral for placement, need for extensive supports, language abilities, medical needs, and family involvement. Three annual PSP meetings were observed by the monitoring team during the week of the onsite monitoring tour. <u>Protections, Services, and Supports</u> The PSP for each individual noted a variety of needs, required supports, and objectives for the individual while he or she lived at MSSLC. Information regarding the PST's review, consideration, and discussion of movement to the most integrated setting was found in the Living Options Discussion (LOD) section of the PSP. The PSP meeting, including the living options discussion (LOD), was led by the QMRP. The comprehensiveness of the discussion reported in the Living Options Discussion Record (LODR) pages was fairly consistent across all of the PSPs reviewed. Overall, there appeared to be little, if any, discussion of an ideal, optimistic vision for the individual; characteristics and components of an ideal living arrangement; or individual considerations for community living.	Noncompliance

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		Given that this set of PSPs spanned the previous 12 months, and given that the process was being changed, a specific metric regarding the number (or percentage) of PSPs that contained, or did not contain, components related to section T is not provided in this review. The monitoring team noted, however, that the more recent PSPs (especially those that occurred subsequent to the facility's receipt of the baseline monitoring report in late May 2010) appeared to contain more detail and discussion regarding an optimistic vision for the individual than those conducted during the prior months. Examples of improved individuality in the optimistic vision statements are presented below. These are limited to these more recent PSP LODs. They represent LODs from individuals from all units at MSSLC. • Individual #433: reside in four-bed, three-bath house with a fenced yard, swimming pool, basketball goal, and a dog. Other characteristics were a bedroom painted red and black, a TV, a game system, and a stereo. • Individual #98: reside in a five-bedroom, near Houston, with a fenced yard, five pit bull dogs, a BBQ pit, a basketball goal, a TV and pool table, a Toyota Freestyle, and posters of rappers. She wanted to work at Footlocker. • Individual #383: she was unable to express herself. Her PST noted that she might like to live in a three- or four-bedroom home near her family, have her own bedroom, and be able to relax and watch TV. The home should have a fenced yard and patio. • Individual #570: ensure he had favorite staff members present. He might live in a small home with similar peers, and have opportunities for outdoor activities and community trips, and be able to watch TV game shows. • Individual #509: live in a quiet environment with an emphasis on behavioral supports. She should have access to her family, receive personal attention, have opportunities for outdoor activities, and be able to listen to soft music and Gospel music. • Individual #541: she should have regular family contact. She should have opportunities for dressing up and participating in parties and fashion shows, listening to music, and watching TV. It would be important for her to have access to a large hospital nearby. Some examples indicated that more work still needed to be done. For example: • Individual #449: the optimistic vision was for him to live on the MSSLC Shamrock unit. • Individual #100: his optimistic vision was one partial sentence, "reside in an alternate environment in a home in (blank)." The blank space gave the	

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		impression that this was a predetermined standard sentence. The LOD then addressed needed supports. These were based on a predetermined list of categories (e.g., medical, behavioral) and many important supports were identified. These supports, however, were often generic and identical across individuals. Further, there was little connection between the detail in the optimistic vision statement and the list of supports. It is likely that the optimistic vision will not include all of the supports needed by the individual, but the list of supports should be more inclusive of items in the optimistic vision. The discussion about the ideal optimistic vision should focus on the components of an environment that would best suit the needs and preferences of the individual, ensure safety, and provide adequate habilitation (including habilitative services, skill development and maintenance), and quality of life activities, such as leisure and recreation activities. The optimistic vision should not merely be a listing of the individual's preferred items. If so, it will not meet the goals of the LOD. Further, it is likely to create confusion and false expectations for the juvenile and adult alleged offenders at MSSLC (e.g., desire to have five pit bulls). MSSLC staff were well aware of the many problems with the current PSP meeting and LOD discussion. As noted throughout this section of the report, changes were anticipated, new training was being scheduled, and a more vibrant and engaging PSP meeting and LOD discussion should be evident during the next onsite monitoring tour. Six annual PSP meetings occurred during the week of the onsite monitoring tour. Three were observed by members of the monitoring team. The content of each of these LODs was inadequate to meet the requirements of this provision item. Details are provided below for one of these meetings. • The annual PSP meeting for Individual #483 was observed by the monitoring team. He was 16 years old and actively participated in the meeting. He had a history of exhibiting challenging aggressive and violent behaviors, and these continued to occur at MSSLC. The LOD occurred at the beginning of the meeting and began with a discussion of an optimistic ideal vision. The movement of the LOD to the beginning of the PSP meeting was a nice improvement from the baseline monitoring tour. As was typical at MSSLC LODs, the individual talked about what he would like, such as living in one of two small towns, in a big brick house with five bedrooms and three bathrooms that also had a patio. He wanted white wood paneling, a Texas Longhorn rug, pictures of his family, a 32 inch flat screen TV, a stereo, and "every Playstation I can get." As indicated above, it was fun and motivating for the individual and his PST to talk about these types of characteristics. The optimistic vision component of the LOD,	

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		however, should also focus on the type of environmental characteristics that would lead this adolescent to have a successful life. The LOD then addressed supports and the PST went through the typical categories. Some good discussion then ensued, particularly regarding recent behavioral incidents and a possible contingency of 90 days with no behavioral incidents leading to another PST meeting to discuss possible referral. The individual seemed motivated. Individual therapy was also recommended by the team. (As indicated in section K of this report, the absence of any individualized positive reinforcement system to motivate and support desired behavior was evident to the monitoring team.) <u>Obstacles to Movement</u> There was no coordinated plan or approach to address obstacles to movement to the most integrated setting across the facility. The facility maintained a record of the obstacles on an individual basis called the Barrier Report, but this list only indicated one obstacle from a predetermined list of about a half-dozen obstacles and did not include all of the individuals at MSSLC (approximately 200 individuals were on this list). There was no summary of this information and data, and no way to understand how the facility was addressing these on an individual or on a facility-wide basis. Moreover, some individuals likely had more than one obstacle to placement. Each individual's PSP had an action plan "to reside in a less restrictive environment," "to participate in activities to prepare for community," or similar wording, but there was no clear tie between the items identified as obstacles and specific action plans, training plans, or service supports as required by this provision item. Further, some examples indicated that more training was needed regarding the identification of obstacles and the need for the implementation of strategies to address these obstacles. • Individual #383: the LOD noted that there were no barriers, but the PST recommendation was to stay at MSSLC. More explanation was needed in this case. • Individual #509: the LOD listed three barriers: no ability to indicate preference, MRA not available, and lack of family response. Strategies and actions related to these barriers were not specified. Approximately 40 individuals were noted as requesting placement. These individuals were not referred due to a variety of reasons, as follows: • Behavior and psychiatric instability (23 individuals) • Pending a risk assessment (six individuals, however, some of these were noted as long ago as January 2010, e.g., Individual #40, Individual #221). • LAR choice was listed as the reason for four individuals. It was likely that LAR choice was the obstacle for many other individuals at MSSLC. This list only	

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		included those who had the capability to express their preference. • Medical instability: two individuals • Citizenship: two individuals • Exploring other options: two individuals • No MRA representative at meeting: one individual • Other: one individual (the reason for other was not stated). Strategies to overcome these obstacles did not appear to be in place at MSSLC. Any plan to identify and overcome obstacles should include strategies that: • are measurable, • identify a person(s) responsible for their implementation, • identify expected time frames for completion, and • are reviewed regularly and modified as necessary.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	MSSLC was engaged in a number of activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in, or was planning to engage in, each of the five activities listed in the DADS policy. Further work regarding the provider fair and tours of community providers is needed as indicated below. This provision item is rated as being in noncompliance due to the need for further activities to occur as indicated in some of the paragraphs below. First, MSSLC had conducted a fair for all providers to present information to interested individuals, family members, LARs, staff, and families from the community. It occurred on 6/1/10. Based upon information submitted to the monitoring team, there appeared to be good attendance by providers, staff, and individuals. Few family members or LARs attended, but this was not surprising, given the amount of travel that would be required. Individuals were placed at MSSLC from all over the state, not solely from the local catchment area. Attendance at the fair included 17 different providers, five staff from the local MRA, 119 MSSLC staff, and 87 individuals. In order to ensure that good outcomes are obtained from the provider fair, MSSLC should consider ways of making the provider fair more effective. One way to do so is to determine specific goals and objectives (i.e., outcomes), a way to measure them, and a way to evaluate the overall effectiveness and success of the fair. In addition, the facility might focus on increasing attendance, providing family members with sufficient guidance before the fair and then escorting them during the fair to ensure that they have an opportunity to interact with providers who might best meet their family member's needs, and helping providers prepare to answer the types of questions most often raised by family members.	Noncompliance

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		Second, interactions occurred between the facility and the local MRA, such as a quarterly meeting with the APC, but it was unclear whether any type of annual community living options inservice occurred for family members and staff. Donnie Wilson, DADS central office continuity of care coordinator, conducted training for QMRPs and other staff at MSSLC for a total of four hours on 7/22-23/10 regarding living options, the community referral process, and the community placement process. This training was one component of the upcoming changes and anticipated improvements to the PSP and LOD processes. Sign in sheets indicated that 96 staff attended. The content included detail regarding the following: • the individual and LAR's awareness and knowledge of community living, • the individual and LAR's preferences, • supports and services needed (e.g., safety, mobility, medical, behavioral/psychiatric, employment/day/school, quality of life), • essential and nonessential supports (with lists of possible supports and services an individual might need), • identification of obstacles, • plans to overcome obstacles, • typical LAR reluctance reason possibilities, • MRA input and recommendations, and • a detailed description of the full community referral process. Third, a Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) was in place for all individuals. It was implemented by the CLOIP worker from the contracted MRA. The purpose of the CLOIP was to educate individuals and family members about community living options. The results of these processes were recorded on a worksheet. Newer PSPs included this information in the body of the PSP document making it more accessible to PST members as well as to the monitoring team. Fourth, the facility took individuals on visits to community providers. A data/information sheet was completed for each tour. It contained relevant information, such as the individuals participating, staff who accompanied, the sites visited, and the individuals' responses to the visit. The information given to the monitoring team, however, indicated that very few tours of providers occurred and that very few individuals participated. The information indicated that: • April 2010: two trips for a total of four individuals • May: one trip for one individual • June: no trips	

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		• July: two trips for a total of two individuals • August: two trips for a total of three individuals • September: two trips for a total of six individuals To improve this process, some type of summary data or tracking database is needed to determine if all individuals who were supposed to have these opportunities were indeed presented with these opportunities, the number of times each individual went on a visit, the goal and outcome of the visit for each individual, and whether the visit was in line with the information in the living options discussion section of the PSP. Fifth, a living options discussion was required to occur and this, as noted above, was occurring at every annual PSP, however, more work was needed (and was being planned) to have these discussions be more comprehensive and meaningful. Finally, although not solely related to education about community placements and providers, MSSLC had a self-advocacy group. A new facilitator was recently assigned and meetings were recently re-initiated. This presents possible opportunities for education regarding community placement (also see section E above).	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. The facility did not provide the monitoring team with any relevant information regarding assessing individuals for placement, however, a list of individuals described as being assessed for placement was submitted to the monitoring team. It listed all individuals at MSSLC and whether or not each individual was referred for placement. The APC noted that the facility was working on a tool and method for assessing each individual for placement and was considering piloting a commercial assessment tool. The facility considered the assessment for placement to include the LOD at the annual PSP. In addition, for alleged offenders, a risk assessment was required for community placement. The facility was awaiting guidance from DADS regarding this provision item. Consequently, it is rated as being in noncompliance. Note that the CLOIP should not be considered an assessment for placement. Its primary purpose was to document that attempts were made to inform the individual and LAR about community placement options and to document the individual and LAR's preferences for placement.	Noncompliance
T1c	When the IDT identifies a more	The Monitoring Panel will discuss the expected criteria further, and would like to discuss	Noncompliance

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	integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	this with DADS and DOJ in further detail. Ensuring adequate transition planning will require looking at the entire transition process from start to finish. Part of the problem at this time is that teams were only beginning to define important and critical supports and services (called essential and nonessential supports in the CLDP process) at the time the CLDP was developed. If this process was started earlier, such as when the PSP is developed (especially for those individuals who are referred during the annual PSP), then the CLDP would flow from the essential and nonessential supports that already had been identified. Generally, transition planning should start at least at the point of referral. This would allow for transition activities, such as visits to providers and the supports needed with that process, to be defined, and for individualization to occur with regard to numbers of visits to potential providers, training to the provider staff, and so forth. Finally, starting over in the CLDP process (in terms of defining needed supports) also means that supports and services that individuals need are likely being missed or not adequately defined.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The DADS policy on most integrated setting practices #018.1 provided detail on the development of the CLDP. The policy directed the PST to work in coordination with the MRA to develop and implement the CDLP in a timely manner. It also directed that a representative of the individual's PST submit a current assessment and/or discharge summary for inclusion in the CLDP. Thirty-six CLDPs and their associated documents (i.e., PSPs and post move monitoring checklists) were submitted to the monitoring team and were reviewed (full assessments were not submitted by the facility). As was the case for the PSP process noted above, the CLDP document and the process for managing the CLDP was also being updated. A new form was in development and recent training had been conducted by the DADS central office continuity of care coordinator. The CLDPs, PSPs, and post move monitoring checklists reviewed represented individuals from all five units and different lengths of time since CLDP development and placement within the 90 days prior to the onsite monitoring tour. The monitoring team appreciated the facility's inclusion of information for individuals who were placed during the time between submission of documents to the monitoring team and the first day of the onsite tour. Overall, processes were in place at MSSLC for this provision item. Moreover, MSSLC directed transitional activities to all individuals at the facility, that is, from all units and with all differing levels of needs, preferences, abilities, histories, and challenges.	Noncompliance

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		At MSSLC, the CLDP was developed after a provider was chosen and a specific home was identified. This was typically only two to three weeks prior to the individual's move. Although activities had occurred prior to the CLDP meeting (e.g., referral, home visits, exchange of information), some of the CLDP topics might be better addressed, or at least initiated, much earlier to allow team members more time to participate and plan, especially, in regards to the development of lists of essential and nonessential supports (as noted above). The CLDP activities were coordinated and managed by the APC and the post move monitor. They gathered documents, put together a draft CLDP, and organized and ran the meeting. This provision item addresses the assignment of responsibilities for implementation of the CLDP. This was primarily indicated in the CLDP in sections V. and VI. and was standard in all CLDPs. The CLDP also included a list of essential and nonessential supports, each of which was assigned to a staff member at the provider agency or at the facility. Essential and nonessential supports and their implementation responsibilities are addressed in section T1e below. A CLDP meeting was held during the week of the monitoring tour and was observed by the monitoring team as well as by the DADS central office continuity of services coordinator. The meeting and its generation of essential and nonessential supports is addressed in section T1e below. Recently, the CLDP was revised to include updates of assessments, completed by discipline department heads or therapists. Full assessments, records, and reports were still included in the overall referral packet, but the CLDP document itself now only included updates. This was an improvement over the previous system that often included lengthy and somewhat outdated information that was not helpful to the CLDP process. The provision item on assessments is addressed below in section T1d. At MSSLC, the CLDP document was an appropriate length and contained information about the individual, including for example: • method of communication • behavioral issues • adaptive equipment • diagnoses • medications • history • a summary of assessments (e.g., social, medical, psychological, daily living skills,	

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		vocational, leisure and recreation) • essential and nonessential supports • signatures from the SSLC, MRA, and Provider • a description of monitoring activities • agreements The monitoring team was very pleased to see that DADS central office had responded to comments made in the baseline monitoring report and had begun a review of CLDPs for comprehensiveness, content, quality, and consistency. The reviews of 24 CLDPs were given to the monitoring team. They ranged from one page to four pages. They provided a lot of good feedback on the CLDPs. This is a valuable activity that should have an impact on subsequent CLDPs. Facility staff should read these reviews thoroughly and use them to inform and improve future CLDPs. There were three different formats to the reviews, either due to the reviews being completed by three different central office staff, or due to changes in the format over time. Either way, one format should be decided upon. In the opinion of the monitoring team, the most important focus of these reviews should be upon whether the list of essential and nonessential supports includes all supports that should be included, whether the supports are defined clearly, and whether there is a method to determining whether the support is or is not present.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs included indication that the APC and/or her staff had responsibility and had agreed to the contents of the CLDP. (Actions specific to essential and nonessential supports are considered in section T1e below.) Each CLDP also referred to a specific date for moving to the new placement.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Signatures indicated that guardians or LARs (when any existed or were appointed) were informed of the CLDP and participated in the process. A signature of the individual was included in each of the CLDPs for those individuals who were capable of signing.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	As per the DADS policy #018.1, current comprehensive assessments were provided to the receiving agency or provider as per report of the Admissions and Placement Coordinator. A full set of assessment documents for the CLDPs was not provided to the monitoring team. The APC kept a detailed checklist of all of the required assessments and summaries to help ensure that all required documents were submitted. It appeared that	Substantial compliance

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		all standard assessments were provided to the providers within 45 days of the individual's move to the community.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	A key part of the community placement process was the identification of essential and nonessential supports. Essential supports were those program components that were required to be in place, that is, those that were essential to the success of the individual's transition. Nonessential supports were those that were very important, but would not serve to prevent a move from occurring. Even so, the expectation was that all nonessential supports needed to be in place and addressed. Nonessential did not mean not needed. The APC and the PMM described the facility's process for creating a list of essential and nonessential supports to be a work in progress. They described the process as occurring during the CLDP meeting. The APC reported that she also reviewed the individual's assessments in an attempt to ensure that the CLDP content was consistent with the assessments. Each of the MSSLC CLDPs had a table that listed out essential and nonessential supports. MSSLC continued to struggle with ensuring that all supports were included in the CLDP. At the time of this onsite tour, the facility was still working on responding to the baseline report, that is, to ensuring that all required and appropriate supports were included in the CLDP. The facility had made efforts to review all of the CLDPs back to May 2010, but had not completed this task. Initial efforts mistakenly did a restatement of the contents of the entire CLDP instead of focusing on (a) whether any important supports were not included in the original CLDP, (b) describing and defining those missing supports, and (c) ensuring those missing supports were addressed. The most recent CLDPs attempted to include more detailed information (e.g., requiring documentation of activities), but each was fraught with missing supports, absence of a way to determine if all supports were in place, and, in some cases, absence of an assigned responsible person. The CLDP meeting for Individual #241 provided a good example of some of the problems with MSSLC's CLDP process. Comments regarding this meeting may be more helpful to the facility than an additional listing of examples of missing supports from the CLDP documents reviewed by the monitoring team (examples were provided in the baseline report, and more recent examples were provided in the 24 DADS reviews of MSSLC CLDPs). In general, the individual presented with need for a variety of supports that were not thoroughly considered by the PST.	Noncompliance

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		Individual #241 was an engaging young man who actively participated in his meeting. He spoke well and expressed his preferences and concerns throughout the meeting. He was personable, but had a history of serious challenging behaviors, such as aggression. He was placed at MSSLC under the Texas court system criminal code 46B. The CLDP meeting was attended by a variety of people, including the post move monitor who led the meeting, two staff from the local MRA, a nurse, QMRP, psychologist, master teacher, primary care physician, direct care staff, the program director of the community provider agency, and two other MRA staff via speakerphone. In addition, the meeting was observed by the APC, the director of QMRP services, and the DADS central office continuity of care coordinator. Early in the meeting, a move date was set for 20 days because the court needed to be notified of the move (i.e. otherwise the PST might have chosen a shorter amount of time). Then, the typical agenda of a CLDP meeting was followed. During the meeting, many important topics were discussed thoroughly and adequately, such as ensuring that his weight was maintained. Even so, a number of comments were made by the individual and PST members throughout the meeting that should have caused the PST to give pause and ensure that everything was in place for this young man before moving ahead with a move date. As he said during the meeting, "This is the one chance I got. I don't want to mess it up." Proper CLDP planning should help, not reduce, the likelihood of his success. • Having cigarettes and money to buy minutes on his cell phone were extremely important to him, but there was not a plan to ensure he'd have money to make these purchases. • Working at a job was important, but there was no plan for him to have a job other than to work with DARS. Employment was important because it would give him something meaningful to do and provide income. The CLDP had "a good paying job" as a nonessential. • He had a history of social and relationship problems and said that he had "trouble with girls." Apparently, he recently moved on campus to a home next to a women's home and this had set the occasion for some type of behavioral outbursts. The CLDP had "male mentor" as a nonessential. This was not defined in any way that could be implemented or monitored. • Social skills training should have been included, perhaps as a nonessential. It seemed to the monitoring team that he could benefit from individual (and perhaps group) training activities around a variety of social skills, such as relationships with women, accepting limitations and feedback, and appropriately negotiating for things he wants. • He participated in anger management class and had a BSP at MSSLC. The CLDP referred to "ongoing anger management training" and "continue current BSP at least 30 days" as nonessentials. These were not defined in any reasonable manner and, further, were likely to provide an insufficient amount of support for	

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		this individual. • Psychiatry services were noted to be a nonessential, but this should be an essential, especially given the difficulty in finding psychiatry providers in the area to which he was going to be moving. • The CLDP listed "transitional counseling" as a nonessential. First, this should be an essential (i.e., in place at the time of the move). Second, the community provider said this would be done by residential staff. This needed to be explored, such as what would they do, what was their training, how would it be monitored, and whether this was an appropriate type of transitional counseling for this individual. • He had relationships with MSSLC staff and other individuals that might be important to maintain. This was only tangentially discussed. • He liked to, and planned to, ride his bicycle independently. This was not addressed at all in the CLDP. • There was no plan for including any type of self-management or positive reinforcement systems to support his appropriate behaviors and success in his new placement. The facility sent the updated CLDP document to the monitoring team following the onsite visit. The revised document indicated that some of the above questions were being addressed. It also contained a list of questions raised by the DADS central office continuity of care coordinator that were answered on 9/30/10, a few days prior to his scheduled move. Without intervention by the continuity of care coordinator, and the presence of the APC, the monitoring team believes that the placement would have likely moved ahead without these important factors having been addressed. Even so, some, but not all, of the issues raised by the monitoring above were addressed. It was the understanding of the monitoring team that upcoming changes in the policy on most integrated setting practices would include a focus on improving the process of identifying and following up on essential and nonessential supports. A draft revised CLDP form and process was shared with the monitoring team. To repeat from the baseline report, it is expected that the essential/nonessential section of the CLDP process will be modified at MSSLC to: • ensure that all needs identified in the individual's current assessment are indicated as essential or nonessential supports, • define each of these essential and nonessential supports in more detail, and • specify the support in a manner that can be measured or verified. In an attempt to obtain information regarding the transitions of individuals since May	

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		2010, DADS conducted a two part telephone survey of providers who were serving individuals from MSSLC. One part was about the individual's transition, the other part was about the provider's experience with the transition process. At the time of the onsite tour, results were not yet available, but preliminary reviews indicated the response was positive from providers. Although this was good to hear, it did not negate the need to ensure that important supports are not left out of the CLDP. For example, an individual with a history of alleged sexual offending or other violent behavior may have adjusted well to his or her move with no exhibition of any serious behaviors during the brief time since the transition (e.g., since May 2010). Moreover, the provider may describe the transition process as having gone very smoothly. The occurrence of a serious behavior, however, at some future point (e.g., after a year or two years in the community) is not out of the question for many of these individuals and any occurrence will raise questions about whether proper supports were in place, such as counseling, psychiatry services, restrictions on contact with children, and so forth, especially if those needs were identified by the facility in various social histories, clinical recommendations, and assessments.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	There was no quality assurance process in place at MSSLC regarding this section T of the Settlement Agreement and the APC indicated that this was in development. Even so, some progress was observed. The APC and a quality assurance staff member both used the monitoring team's checklist tool to monitor section T1 for one individual, and section T2a for a second individual. The results were included as part of the PET III meeting. This was a new process that had occurred. Monitoring of the LOD section of the PSP was discontinued in March 2010 when the post move monitor was reassigned to a larger caseload of CLDPs. The APC expected LOD monitoring to start again when the additional transition monitor positions were filled and those new staff were trained.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this	MSSLC was not in compliance with this provision item. MSSLC was not gathering, and was not analyzing, information related to identified obstacles to individuals' movement to more integrated settings. Please also see the discussion in section T1b1 above. MSSLC did not have a comprehensive assessment related to the provision of community services to people with developmental disabilities and obstacles to such placements. Further, as indicated in this provision item, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. The APC and her staff were knowledgeable about many systemic obstacles to placement (as compared to the	Noncompliance

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	information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	individuals' obstacles) and this information, for example, could be incorporated into the facility's comprehensive assessment. Two of the factors competing with successful placements were minimal options for community employment and a lack of competency in important community living skills, especially those that can set the occasion for problem behaviors in the MSSLC population (e.g., social skills, money management). At the time of the onsite monitoring visit and subsequent preparation of this report, DADS was in the process of developing an assessment and report to meet the requirements of this provision item. The monitoring team appreciated having had the opportunity to review a draft of this document and provide suggestions to DADS.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to,	A document was given to the monitoring team that listed 67 individuals who had moved to the community since 1/1/10 in response to a request for a Community Placement Report. The document did not contain a list of those individuals who "can be appropriately placed in the community and receive community services" as required by this provision item. Note, however, that the facility provided a separate list of individuals who have been referred for placement. To meet this provision item, the facility needs to put this information into one report. Further, the report should include individuals whom PSTs have determined can be appropriately placed in the community and receive community services even if these individuals have not been referred for placement. In other words, the Community Placement Report might contain three sections listing those who have been placed in the community, those who have been referred, and those who can be appropriately placed but have not been referred.	Noncompliance

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	medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	MSSLC was implementing the post-move monitoring process, however, a number of changes had occurred since the baseline monitoring tour and new changes were in process. First, three new post move monitors were assigned by DADS central office to conduct post move monitoring visits over the past few months. This was due to a need to allow the post move monitor at MSSLC time to focus upon the CLDPs and also to provide additional assistance given the many placements made by MSSLC over the past year. Second, the APC planned to hire three transition monitors, as described above, to conduct post move monitoring. This was not yet in place. Post move monitoring checklists were reviewed for 10 individuals, with examples from all five of the MSSLC units and ranging in time of placement across the previous 90 days. Some of the post move monitoring visits did not occur within the required timelines (e.g., Individual #453, Individual #243, Individual #530). This had been corrected by the time of this onsite monitoring tour, according to the APC. Overall, the reports indicated that essential and nonessential supports were in place or there was a plan for them to be put in place. Not all post-move monitoring visits included a visit to the residence. Every post move monitoring visit needs to include a visit to the residence. The site or sites visited was not, but should be, included on the post-move monitoring checklist. The state should consider adding this to the post-move monitoring form. A review of the post-monitoring visit checklists indicated that the PMM followed up on items that were not yet in place. For example, adaptive equipment, an essential support,	Noncompliance

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		was not in place for Individual #530. The PMM eventually contacted the community agency nurse and it was resolved. The post-move monitoring was completed by the APC, the PMM, and the three central office PMMs. In addition, PMMs from other facilities completed the checklist forms for two of the individuals. There were differences in the way the forms were completed. Some included notes within each section of the form, others had notes at the end. The forms with more detailed notes (done by the PMMs from the other facilities) provided a more thorough understanding of the status, issues, and concerns for the individual's transition. Many, on the other hand, had few or no comments at all (e.g., Individual #243, Individual #597). This was particularly noteworthy given that problems at Individual #597 's home led to him being transferred to a new home with the same provider. There was nothing in the checklist form to indicate that there were any problems at all with the first placement site. Some checklists also included a description of the methodology and activities engaged in by the PMM. This was helpful to the monitoring team. Most items were checked as Yes, but no supportive or background information was provided. Further, evidence indicating that essential and nonessential supports were in place was not described, obtained, or attached to these checklists. The facility should consider having the CLDP process include a specification of the manner in which the PMM determines the presence of each essential and nonessential support and the type of evidence that must be provided by the PMM. Without doing so, it will remain difficult to determine whether or not a support was present, such as for, "opportunities to participate in activities of his choice" (Individual #84). Obtaining the money from the individual's account at MSSLC (called a trust fund) appeared to be difficult to accomplish, and to take a long time. Facility and state staff should look into this process and come up with a way for individual's to receive their funds more expediently. For some individuals, this can be particularly problematic if the money is needed for personal supplies or other items important for their transition. The monitoring team also recommends that the post move monitor have the opportunity to network with other post move monitors and with DADS central office to ensure support, exchange of ideas and best practices, and problem solving. The APC and PMM reported that they had a very good working relationship with the providers and had not needed to resort to notifying the MRA, DADS, or any regulatory agency in order to gain their compliance in providing any of the required supports.	
T2b	The Monitor may review the	As noted above in section T2a, post-move monitoring visits were occurring at MSSLC.	Noncompliance

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	accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The monitoring team had the opportunity to accompany the post-move monitor on a visit to the home of Individual #597, who had moved to the community within the previous 90 days. The home was operated by Ruth Marie's Country Homes, a relatively new provider that operated 16 homes in the area. The individual moved into this home only a few weeks prior to this visit, but had been served by the same agency in a different home since his transition to the community. Apparently, the first home was noisier and busier and the individual appeared to not like it (based on his limited means of communication). The agency obtained another home in a more rural setting and this individual and two others from MSSLC moved in. The individual appeared happier and content in this new home. It was pleasantly furnished, he had his own bedroom, and was staffed by one employee around the clock, except when everyone was at day program. This was the 90-day post move monitoring visit. The PMM took a tour of the home and sat with the agency's owner and agency's vice-president at the kitchen table to go through the checklist form. The PMM asked for a staff schedule (but only for the current week) and to look at four inservice sheets (but did not crosswalk the signatures on the inservice sheet with the staff schedule). She was given verbal answers to questions about the individual's bank account, rep payee status, use of vehicles, and doctor's appointments (though the agency said it would fax info about doctor's visits to her the following day). The PMM gave a "pop quiz" to the direct care staff about the individual's diet and the staff member answered correctly. Also, the staff member had previously worked with the individual at MSSLC and appeared to have a good relationship with him. Overall, the post move monitoring visit was done pleasantly. Moreover, the individual appeared to be doing well and was being supported by an agency that appeared to care about its performance. The presence of the agency's owner and vice president during this post move monitoring was a function of their desire to support the staff and learn about the process. They were not aware of the Settlement Agreement nor of the monitoring team's plan to attend this visit. Obtaining substantial compliance with this provision item will require implementation of a more thorough review of evidence. This will only be able to occur if the description of supports is made more detailed and observable as indicated in sections T2a and T1e above.	
T3	**Alleged Offenders -** The provisions of this Section T do not	There were 16 individuals to whom this provision item applied, from 1/1/10 through 8/18/10.	

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	apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that	MSSLC identified four individuals to whom this provision item applied (Individual #587, Individual #516, Individual #263, Individual #36). The discharge packets did not indicate how the discharge met any of the criteria of this provision item. One of the discharges was to another SSLC for more acute medical care. The other three were discharges initiated and enacted by family members. One of these discharges was to a nursing home, and one was a return to live with the family. The fourth individual was not returned to the facility after a home visit. In all four cases, the PST approved the discharge. Discharge packets of information were reviewed by the monitoring team. The packets did not indicate that the individual was transferred or discharged for good cause (e.g., Individual #516, Individual #263, Individual #36). The facility did, however, provide a final summary of the individual's developmental, behavioral, social, health, and nutritional status. The discharge packets did not include a post-discharge plan of care to assist the individual to adjust to the new living environment. It is possible that, after further discussion with DADS, it may determined that section T4 did not apply to these individuals. If so, the facility will need to include these individuals in its discharge process as described in T1 and T2 of the Settlement Agreement and, when appropriate, provide a description as to why those provision requirements were	Noncompliance

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	the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	not followed in these discharges. Further, it would indicate that the facility was not clear on the requirements of this provision.	

Recommendations:

1. Implement updated policies and procedures when they are disseminated.

2. Ensure that the new facility policy is in line with state policies, and obtain documentation from state office regarding the approval of state policies that add to, or supplement, state policies.

3. Ensure that the opinions of professionals (i.e., PST members) are considered when determining most integrated settings. The opinions of these professionals for appropriateness of referral for placement should be considered separately from LAR preference. Further, ensure that the PST follows state and facility policy regarding referrals, reporting of obstacles, and acting when there is a lack of team consensus.

4. Review and modify how the living options discussion occurs at the PSP meeting regarding the optimistic vision for the individual's placement in the community. Ensure that the LOD is thorough and meaningful. Ensure that the LODR is an accurate reflection of the LOD. Ensure that the optimistic vision section of the LOD addresses the individual's needs for success in the community, not only his or her preferences.

5. Identify and address the identified obstacles to individuals' movement to the most integrated setting:
    a. within the PSP meeting LOD for each individual,
    b. across the facility by conducting a comprehensive assessment, and
    c. by developing actions from DADS as required by provision item T1g..

6. Review the list of individuals who have requested placement, but were not referred to ensure that the reasons are current and that any actions that could have been taken, were taken. For example, some individuals were awaiting a risk assessment for more than six months.

7. Continue to work on education of individuals and LARs regarding most integrated setting practices.
    a. Determine measureable outcomes for the provider fair.
    b. Increase the number of individuals who go on tours to community providers. Track the individuals who go on specific tours to ensure that the tour is an appropriate one given the needs of each individual.
    c. Use the self-advocacy group as an opportunity to educate individuals.

8. Create an assessment for placement as required by provision item T1b3.

9. Improve the way important essential and nonessential supports are included in the CLDP:
    a. Consider ways to begin developing the list of supports prior to the CLDP meeting.
    b. Ensure all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
        i. define each support in observable and measureable terms.
        ii. define the manner in which the presence of each support will be verified.
    c. Ensure all professional disciplines are included in the transition and placement process, including, but not limited to, physicians and psychiatrists.

10. Develop a quality assurance process for provision T. Ensure that relevant information is submitted and monitored by the QE department. Ensure that quality assurance processes are applied for all of section T, including but not limited to T1g.

11. Revise the post-move monitoring checklist to include detail regarding (a) each of the sites visited, (b) how the presence or absence of supports was assessed, and (c) follow-up activities for both essential and nonessential supports.

12. Create a Community Placement Report.

13. Ensure individuals are properly considered as meeting any of the criteria for provision item T4.

The following are offered as additional suggestions to the facility:

14. Continue to provide feedback to the facility on the CLDPs. Consider creating a metric to measure the quality of the CLDPs and consider creating a criterion to indicate that the facility has mastered CLDPs. This might then result in less frequent reviews of CLDPs being necessary.

15. Re-institute monitoring by the PMM of the living options discussion of the PSP meetings.

16. Provide opportunities for the post-move monitor to network with other post-move monitors at other facilities.

17. Examine the failed placements of any individuals to determine if any improvements should be made to the referral and transition processes.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o PSPs listed in Section F of this report Interviews and Meetings Held: o Lloydette Harris, Rights Officer o Valerie McGuire, QMRP Director o Lynda Mitchell, Assistant Ombudsman Observations Conducted: o Observations at all residences o Observations at the onsite workshop, greenhouse, and active treatment classrooms o Shamrock Unit Meeting 9/14/10 o Daily Incident Management Meeting 9/14/10 o Daily Incident Management Meeting 9/15/10 o PSPA for Individual #300 9/15/10 o PSP for Individual #378 9/13/10 o PSP for Individual #37 9/16/10 o Whiterock Health Status Team meeting 9/14/10 o Human Rights Committee meeting 9/14/10 o Restraint Reduction Committee meeting 9/16/10
	Facility Self-Assessment: The facility's POI indicated that the facility had developed a prioritized list of individuals in need of an LAR and was waiting on further direction from the state office in terms of a policy to address this provision. They had assigned a rating of noncompliance to all items in this provision. The monitoring team agrees with the finding of noncompliance for this provision.
	Summary of Monitor's Assessment: The facility had not begun to formalize a process for identifying individuals in need of LARs or identifying resources for finding guardians. The facility provided the monitoring team with a list of 14 individuals in need of an LAR. A review of PSPs indicated that this was not a complete list of individuals at the facility who needed an LAR.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The facility had a Rights Officer that was responsible for the development of a process to address this provision item. Not all PSPs included discussion on whether or not the individual needed a guardian or advocate. For example, for two individuals without a guardian or active advocate (see below), there was no indication that the team formally discussed this need: • The PSP for Individual #227 indicated that she did not have an LAR, but did have an advocate. The PSP referenced noted that a guardian/priority tool had been completed and it was determined that she did not require a guardian. Her brother and sister-in-law were listed as her primary correspondent. The PSP indicated that the MRA had spoken with her brother regarding community living options prior to PSP development and he stated that he was not interested in receiving community options information because he did not expect his sister to move from MSSLC. No other contact with this brother is documented in the PSP. He did not attend the annual PST meeting or any of the frequently held PST meetings to discuss changes in status. • The PSP for Individual #398 indicated that she did not have an LAR, guardian, or primary correspondent. PSPs at the facility revealed that the PSTs engaged in limited discussion regarding guardianship. According to the Rights Officer, the process for identifying individuals who needed LARs had not been formalized to include consistent criteria that teams could use to determine priority need. The facility was not in compliance with this provision item.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for	The facility had not yet established a process for obtaining LARs for individuals identified as needing guardianship or advocacy. One advocacy agency had been identified and contacted in regards to advocacy services for the 14 individuals at the facility identified as being in need of advocacy services. The facility was not in compliance with this provision item.	Noncompliance

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	individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.		

Recommendations:

1. Develop a prioritized list of individuals who need LARs.
2. Develop a list of LAR providers in the area.
3. Provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming a LAR.
4. Consider ways of teaching individuals to problem-solve, make decisions, and advocate for themselves. Some of these skills might be addressed with a formal instructional teaching plan.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o MSSLC policy: Documentation of services delivered to clients; Administrative Manual-30, dated 1/30/07 o MSSLC POI, updated 8/26/10 o MSSLC POI Supplement, 8/18/10 o MSSLC Recordkeeping Department Settlement Agreement Presentation Book o Summary sheet from opening presentation made to the monitoring team, 9/13/10 o Table of contents for the active record and the individual notebook o Completed audit sheets of active records done by the URCs and director for July 2010 and August 2010 o Active records of many individuals who lived at MSSLC o Review of active records and individual notebooks of: • Individual #441, Individual #254, Individual #483, Individual #500, Individual #408, Individual #221 Interviews and Meetings Held: o Elaine Schulte, Director of Client Records o Sherry Price and Misty Samuels, Unified Records Coordinators o Charles Bratcher, Director of Quality Services Management o Records clerks for two homes: • Heather Hileman, Debbie Reichert o Numerous staff and clinicians at all levels, including • Angela Johnson, Jessica Barry, Debbie Hogan, Molly Chase, Bertha Allen, Carlos Burrell, Sherry Mimsherry, Rhonda Looney, Frank Brown o Many individuals at their residences Observations Conducted: o Records storage areas in residences, especially Whiterock and Shamrock o Records storage areas in administration building
	Facility Self-Assessment: The facility's self-assessment, called the POI, for this provision indicated that all four provision items were rated as being in noncompliance. Narrative information was provided. It described what the recordkeeping department had been doing and/or was planning on doing. The comments are summarized below.

	• V1.The Unified Record System was temporarily put on hold on 6/11/10 due to there being many concerns from all facilities regarding placement of some documents. On 6/18/10 received a memo from Becky McPherson, stating everything had been discussed and changes were made to the Unified Records Guidelines. On 6/21/10 Sherrie and Misty and all of the program technicians started working on changing all records from the old chart order to the new Unified Record Guidelines for all individuals residing on the Whiterock Unit. As of 6/30/10, all records on the Whiterock Unit are now in the new Unified Record according to the Unified Record Guidelines. As of 8/18/10 all records of all individuals on campus have been switched from our old chart order over to the Unified Record Guidelines. • V2: I am in the process of writing the facility Recordkeeping Policy and implementation date is scheduled for October 1, 2010. • V3: The Unified Record Coordinators have monitored on three occasions as of this month. They will start morning monthly on a regular basis starting September 1, 2010. • V4: Unified Record Coordinators will begin monitoring a staffing each month to ensure that all disciplines are actively involved in the PSP process. Even though a lot of activity had occurred towards this provision of the Settlement Agreement, the monitoring team concurred with the facility's self-assessment regarding this provision. The review that follows below provides some direction for the facility towards continuing to develop its recordkeeping practices to meet the requirements of this provision. Corrective action plans should also be included in the self-assessment actions for these provision items where appropriate.
	Summary of Monitor's Assessment: MSSLC made great progress towards meeting this provision of the Settlement Agreement. The new policy and record keeping practices were implemented across the facility. The unified record for every individual was created, including a reformatted active record and a brand new individual notebook. The unified records consisted of a multi-volume active record, an individual notebook, a master record of historical and legal documents, and an overflow record of thinned and purged materials that were stored for future use if needed. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. A master record existed and contained the required typical documents. The Director of Client Records and the two Unified Record Coordinators were committed to having an organized, user-friendly record keeping system. They were knowledgeable about the records, had many years of experience at MSSLC, and were interested in improving the records as implementation of this new system moved forward. A further indication of progress in this area was that audits of the active records by the recordkeeping

	department had commenced in July 2010. Through the time of the onsite monitoring tour, 26 audits had been completed. Useful information was obtained during these audits. A system, however, was needed to ensure that corrections were made to the records based on the audits. Further, an additional audit tool was needed to ensure that all contents of all components of the record were audited. MSSLC should ensure that record keeping is tied into the facility's quality assurance program and that quality assurance activities occur related to record keeping. Moreover, it will be important for MSSLC to obtain feedback and suggestions from those who use the records regularly in order to make relevant and useful changes to the record keeping system. This was beginning to occur at MSSLC: a task force had been formed to look into the usage of the individual notebooks given the many challenges that were occurring at the facility in the implementation of that aspect of the new unified record system. The monitoring team looks forward to MSSLC's implementation of the new record keeping policy and practices.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	The monitoring team looked to see if MSSLC had established and maintained a unified record for each individual consistent with the guidelines in Appendix D of the Settlement Agreement. MSSLC had made considerable progress in meeting this provision since the baseline tour. At the time of this onsite monitoring tour, all of the records at the facility had been converted, and every individual was reported to have an active record that was in the new format, as well as an individual notebook. The completed unified record consisted of the following, as required: • Active record • Individual notebook • Master record • Overflow files The conversion of the old records to the new active records, and the creation of the individual notebooks was a very large task and required a great deal of effort from the recordkeeping department staff as well as from other departments and operations at the facility. The monitoring team wishes to acknowledge this as well as the ongoing efforts at the facility to meet this provision of the Settlement Agreement. The records were completed only a few weeks prior to the onsite tour and more work was needed (and was going to be done) to ensure they were useable, of a manageable size, and that all aspects of Appendix D were being followed. Therefore, this item was rated as being in noncompliance, however, it is likely that the facility will achieve substantial compliance	Noncompliance

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		in the near future. DADS developed a policy on recordkeeping called Recordkeeping Practices. It was number 020.1 and was dated 3/5/10. It was slightly updated from a previous version in order to more thoroughly define each of the components of the unified record for each individual. The director of client records indicated that she was working on a facility policy to go along with the DADS policy and anticipated completing a draft by 10/1/10. Once approved at the facility level, approval should also be obtained from DADS central office. A policy remained in the MSSLC administrative policy and procedure manual called "Documentation of services delivered to clients." It was labeled Administrative-30, dated 1/30/07, and noted in the baseline report. MSSLC should review this policy to determine if it will be replaced by the policy being developed by the director of client records. If not, it should be modified to be in line with the DADS policy. The facility's records activities were overseen by Elaine Schulte, Director of Client Records, and Sherry Price and Misty Samuels, Unified Records Coordinators (URC). Ms. Schulte had more than 30 years experience at MSSLC. In addition, she was a registered health information technician (RHIT), and a member of AHIMA, a national professional organization. The URCs were also very experienced at MSSLC, having worked there for many years, too. In addition, there were five records clerks at the facility, one for each unit. The records clerks had primary responsibility for managing and maintaining the records under the direction of the URC. The director and URCs described their primary goals as meeting the new policy, and ensuring that records were available, thinned according to schedule, and useable for staff at all levels. They described training that they conducted. Two sessions were offered to increase the opportunities for attendance. It included a PowerPoint presentation on the unified records and the records guidelines. Nevertheless, they said the sessions were sparsely attended, as if the upcoming changes in records were not considered to be important by managers and supervisors. Once the new books were put in place, the URCs noted that many managers and supervisors were surprised by the changes, even though training and educational opportunities were presented to them earlier. In addition, they described resistance from some residential staff on the use of the individual notebooks, such as statements that they were not responsible for the notebooks. Facility management might explore this further to see if any actions might be appropriate to further support these new procedures in recordkeeping practices throughout the facility. The monitoring team had the opportunity to speak with a number of the records clerks	

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		as well as with many staff and clinicians at all levels regarding their experiences with the new record keeping systems. Their comments are summarized below in this section of the report. <u>Active records</u> The new active records varied in size based upon the amount of information in the individual's record. Most records contained three three-inch binders. Some contained only two binders, and others contained four binders. Some contained five binders and there was discussion at the facility about returning to four-inch binders for some individuals. The active records were divided across the binders in the same way for all individuals. The active records were constructed following the order of sections from the state's table of contents. In the opinion of the recordkeeping staff, the active records were neater, more organized, and information was easier to find. They reported that the new plastic tabs were sturdier than what they had been using. They noted that keeping the records in reverse chronological order while using two-sided pages for IPNs and observation notes created a great deal of confusion. They solved this by only using one side of each page for these record sections. New chart racks are recommended where needed; some of the ones observed by the monitoring team were old, misshapen, or clumsily stacked on tables. <u>Individual notebooks</u> Individual notebooks were in place as per the state's policy. Individual notebooks were observed throughout the onsite monitoring tour. For example, five individuals were observed carrying their own individual notebooks, and holding on to them, during the meeting. In another example, individuals at the Shamrock unit approached the monitoring team and eagerly asked if they could show the monitoring team their "blue books" (as they called them). Staff said the books made these individuals feel important. The individual records reviewed by the monitoring team appeared to contain everything required by the state's table of contents. This, however, led to the notebooks being very full (nearly exceeding the capacity of the one-inch binders) and thereby heavier and more cumbersome than the planners of this system likely anticipated. The purpose of the individual notebooks was to ensure that all relevant information was at hand for direct support professionals, however, the monitoring team learned that many of the staff found the individual notebooks to be cumbersome and to be particularly unwieldy during community outings. The monitoring team was also concerned as to whether this might be counter-therapeutic for some individuals,	

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		whether this might distract staff from attending to the individuals, and whether it would create a negative stigmatizing effect. There were other issues regarding the individual notebooks at MSSLC. The facility director had created a task force to examine the use of individual notebooks at MSSLC and to provide him with comments and recommendations by mid-October 2010. This was a good action to take because it will involve obtaining input from those who work directly with the individual notebooks. Below are some of the issues that the committee will need to address: • Confidentiality: staff were reported to have contacted the facility ombudsman regarding confidentiality violations that may occur due to the availability and accessibility of the individual notebooks. • Destruction: some individuals have destroyed their individual notebooks, put them in the trash, or torn up the observation notes when they were aware that staff were documenting an incident about their problem behaviors. • Normalization: at the self-advocacy meeting, one of the individuals said, "That all about me book is not very normal, and they talk about normalization..." Another individual, however, responded, "The books and what staff do is for us, for our protection." • Mobility: discussion needed to occur as to whether certain levels of supervision would not require the individual to carry his or her own notebook. Also, questions about what to do with the notebook when bike riding independently, or when walking alone on campus needed to be addressed. <u>Master records</u> A master record was kept for each individual. Some of the items in the master record were used regularly by some of the departments at MSSLC, such as medicine or psychology. The record keeping staff said that they made sure that documents were available as needed. <u>Overflow files</u> Documents taken from each individual's records were stored and managed by the record keeping staff according to the record thinning schedule provided by the state. A large room was used for these files. <u>Comments on unified records</u>: Although a tremendous amount had been accomplished, the monitoring team found MSSLC still had work to do to meet the requirements of this provision beyond the transfer of records into the new formats and the creation of the individual notebooks. For example:	

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		• The consents section had a number of consents in it, but there was no way to know if the consents in this section represented all of the consents that should be present. Some sort of checklist should be created so that the records clerk (and program auditors) can determine if all consents are present (e.g., Individual #254). • The habilitation section contained a lot of information. Similar to the comments immediately above regarding consents, the monitoring team was unable to determine if any habilitation consultations or notes might have been missing. • Some books had loose papers that had not been inserted correctly. • Individual notebooks did not contain data sheets for SPOs (e.g., Individual #406, Individual #254, Individual #441). • One individual notebook (Individual #441) had a broken ring and papers were falling out. <u>Comments from staff</u>: Below are summarized comments from the many staff who spoke with the monitoring team. MSSLC management should consider these comments as it moves forward with continued development of the new recordkeeping practices at the facility. • A direct support staff member liked the individual notebooks. He noted that everything was now in one place and as a result, for example, staff didn't have to go back into the records room to make notes. • A master teacher noted that the individual notebooks allowed staff to be able to document easier. • A nurse liked the new charts, especially the new individual tabs and sections for all areas. She liked that the IPN section had its own tab. • A nurse and a QMRP noted that they were getting used to the new records. • A psychologist noted that the clerks were now taking observation notes out every night at midnight and that this was a good thing. • A supervising staff member on the Whiterock unit said that staff were not used to the new record systems yet, but that the individual book was helpful, and that it appeared to be a good thing. • The records clerk at Whiterock was responsible for the records for 95 individuals. She liked the new records and found they made it easier to file, and easier to get things. • A supervisor at Shamrock said that the new active records were OK and they were getting used to them. • A records clerk at Shamrock said that she liked the new system and found that new staff learned the new system easier than they did the old version. • Recordkeeping staff said that the physicians have said that not enough information was in these records.	

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		• Clerks noted that physicians and nurses often put their own notes into the record, but that it would be better if they would leave those notes for clerks to file.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	Over the past few months, DADS wrote and distributed new policies to address many, but not yet all, of the provisions of Part II of the Settlement Agreement. More work will be needed to complete the additional policies, and to develop a regular process for the review, updating, and modification of each policy. DADS maintained a spreadsheet indicating the status of policies, protocols, and procedures for each provision in Part II of the Settlement Agreement (i.e., sections C through V). Facility policies are likely to be developed as DADS completes its set of statewide policies. Then, as noted throughout this report, the facility will need to ensure that any facility-specific policies are in line with the state policy and that approval is obtained from the DADS central office.	Noncompliance
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	A quality assurance and quality enhancement procedure to ensure a unified record was recently put into place at MSSLC. MSSLC's quality assurance department, however, was not, but needed to be, involved in addressing this provision item. The Director and the two URCs each conducted audits in July 2010 and August 2010 for a total of 26 active records. This represented a great start to the quality assurance process required by this provision item (also see section E above regarding quality assurance). They used the monitoring team's checklist tool for provision V and they scored the section for V1. Specific comments and detail were provided at the end of each of the audits detailing the items that were missing or inadequate. A lot of useful information was thus provided for program managers and record clerks. A method needs to be put in place to ensure that feedback is received by the program and that the items noted in the audit have been corrected. The monitoring team had the opportunity to discuss the auditing process at length with the recordkeeping staff. The monitoring team appreciated the director and URCs' interest in improving their service and meeting the requirements of this provision item. To do so, the audits should continue, but should include additional information to ensure that all components of the unified record are assessed, as well as the specific required components of each aspect of the unified record. One way to do so is to use the table of content as a guide. It is recommended that the director contact the URC at San Antonio SSLC to learn about her auditing checklists; these would be useful to MSSLC.	Noncompliance

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		In addition, MSSLC should get feedback and suggestions from staff who use the records. This information can be used to improve the record keeping system and components. Implementation of the new record keeping system had only occurred a few months prior to the onsite monitoring visit. Once staff have used the system, useful feedback can be obtained from clinicians, managers, and direct support professionals.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	The facility did not have a means to assess this provision item. The monitoring team discussed this provision item at length with the Director of Client Records and with the two URCs. The facility will have to come up with a way to determine if facility staff are routinely utilizing the records in making care, medical treatment, and training decisions. The facility should work with DADS central office, as well as with the other SSLCS to determine how to do so. Most likely a set of activities will have to occur, including, for example, interviews of clinical staff to learn how they use the records (e.g., psychology, nursing, habilitation), a review of the contents of IPNs, and an examination of medical consultations. The URCs had planned to attend PSP and PSPA meetings, but the monitoring team commented that this was probably not going to result in their obtaining the information they needed to meet the requirements of this provision item. Some comments, based upon observations of the monitoring team, regarding the use of the records as required by this provision item are provided below. These illustrate some examples of the use of the unified record, but also show some of the challenges for the facility to address in meeting the requirements of this provision item. • There was an improvement in the PBSP data collection systems for obtaining accurate data, however, it was not consistently implemented (see K4) • The facility should be commended for its recent reorganization of all individuals' nursing-related records and improvements in recordkeeping practices. For example, records were organized, and nurses' notes were usually in the SOAP (Subjective and Objective (data), Analysis, and Plan) format. It was an infrequent occurrence to find a record note that was illegible, improperly signed and dated, and/or not designated as a late and/or erroneous entry, when/if needed. • In all three psychiatry clinics observed, the psychiatrists appeared to be familiar with the individual's history, and had the medical record open, reviewing documents from the record during clinic. • During the psychiatry clinics, the nursing case manager and the psychologist	Noncompliance

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		provided the psychiatrist with historical information verbally. • There were instances where the psychologist provided information to the psychiatrist regarding target symptoms via a grid and/or graph. Some graphs reviewed, however, showed behaviors that did not coincide with the individual's diagnoses (i.e., an individual diagnosed with depression, but target symptoms/behaviors did not include mood). This was an area that could be improved via the increased collaboration between psychology and psychiatry. • Also, as the graphs reviewed did not include noteworthy events (i.e. medication changes, situational stressors), these graphs were not overly useful. • The lack of computer data access was another challenge. For example, one psychiatrist made it a practice to review the psychology information via the shared drive the day prior to a scheduled clinic. The psychiatrist then integrated that information (inclusive of graphs) into the consultation. Other psychiatrists had not embraced this practice. One impediment to this was the lack of computer access in the residential areas where psychiatry clinics were held. Providing the physicians with laptop computers and read only access to the psychology data would be helpful. • All clinicians interviewed remarked about the challenges they experienced with the record. Psychiatric consultations were included in the integrated progress note section, and, as such, were often buried in pages of notes. Some physicians had begun writing orders, and dating them during clinical encounters in an effort to use the date on the orders to locate prior psychiatric progress notes. Having a shared data folder dedicated to psychiatry, and utilizing computers to type notes (in a quasi-electronic medical record) could alleviate some of these frustrations. Of course, the best option would be a facility wide electronic medical record. • Physicians also expressed frustration because the records were purged yearly, and historical information needed to provide consultation was, at times, unavailable. Information could be requested from medical records, however, the physicians indicated that this resulted in an unacceptable wait time in some cases that required urgent review of the records. Again, some of this could be alleviated by electronic access to prior records. • A dictation service was utilized to assist with report preparation for the SLPs. This had not resulted in more timely completion of assessments. A number of assessments requested as a part of the sample by the monitoring team were unavailable and it was reported that they were still with the service weeks later.	

Recommendations:

1. Finalize the conversion of all records.

2. Ensure facility policy is in line with state policy. Obtain approval from DADS central office.

3. Assess individual notebooks to ensure they are being used as intended, that their size is not too large for the notebooks to be useful, and the manner in which responsibility for carrying the notebooks is assigned. (A new plan/task force was in place to address this at MSSLC.)

4. Complete the development of policies as described in provision item V2.

5. Incorporate record keeping activities into the facility's quality enhancement program, including ensuring the data collected by the Director of Client Records and the URCs during their record audits are included in the QA program.

6. Use an additional checklist audit tool that looks at all of the components of each of the four parts of the unified record. Add to the audit tool detail so that the auditor can determine whether all documents that should be in the record, are in the record, especially for areas such as consent, consultations, and habilitation.

7. Develop a method to ensure that any needs or problems identified in the record audits are corrected.

8. Ensure records are used in making care, medical treatment, and training decisions.

The following are offered as additional suggestions to the facility:

9. Work with the medical department to ensure that the records are meeting their needs, and to obtain suggestions from the medical staff regarding the recordkeeping system.

10. Consider ways of providing "read only" access for clinicians to review reports of other clinicians via the electronic system, such as the shared drive.

11. Obtain new and better racks for the records in the residences.

12. Obtain feedback and suggestions from those staff who regularly use any components of the unified records.

13. Consider an electronic database for records.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACLS	Advance Cardiac Life Support
ADA	Americans with Disabilities Act
ADHD	Attention Deficit Hyperactive Disorder
ADR	Adverse Drug Reaction
AED	Anti Epileptic Drugs
AIMS	Abnormal Involuntary Movement Scale
ANE	Abuse, Neglect, Exploitation
APS	Adult Protective Services
APC	Admissions and Placement Coordinator
ARD	Admissions, Review, and Dismissal
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BLS	Basic Life Support
BM	Bowel Movement
BMI	Body Mass Index
BSP	Behavior Support Plan
BTC	Behavior Therapy Committee
CAP	Corrective Action Plan
CCC	Clinical Certificate of Competency
CD	Compact Disc
CKD	Chronic Kidney Disease
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Assistant
CPR	Cardio Pulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curriculum Vitae
DADS	Texas Department of Aging and Disability Services
DCP	Direct Care Professional
DCS	Direct Care Staff
DDS	Doctor of Dental Surgery
DEXA	Dual-energy X-ray Densiometry

DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Return
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DRR	Drug Regimen Review
DSHS	Department of State Health Services
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
e.g.	exempli gratia (For Example)
EEG	Electroencephalography
EKG	Electrocardiogram
ER	Emergency Room
FDA	Food and Drug Administration
FOBT	Fecal Occult Blood Test
FTE	Full Time Equivalent
FY	Fiscal Year
G-tube	Gastrostomy Tube
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
HCG	Health Care Guidelines
HIP	Health Information Program
HIV	Human immunodeficiency virus
HMP	Health Maintenance Plan
HRC	Human Rights Committee
HST	Health Status Team
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
IDT	Interdisciplinary Team
i.e.	id est (In Other Words)
IEP	Individual Education Plan
IM	Intra Muscular
IMC	Incident Management Coordinator
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPE	Initial Psychological Evaluation
IPN	Integrated Progress Note
ISP	Individual Support Plan
IV	Intravenous
JD	Juris Doctor
LAR	Legally Authorized Representative
LD	Licensed Dietitian

LOD	Living Options Discussion
LODR	Living Options Discussion Record
LRA	Labor Relations Alternatives
LSLA	Licensed Speech and Language Assistant
LSOTP	Licensed Sex Offender Treatment Provider
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAR	Medication Administration Record
MBA	Masters of Business Administration
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MD	Medical Doctor
MED	Masters of Education
MERC	Medication Error Review Committee
MG	Milligrams
MISD	Mexia Independent School District
MOSES	Monitoring of Side Effects Scale
MOT	Masters, Occupational Therapy
MR	Mental Retardation
MRA	Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphyloccus aureus
MS	Master of Science
MSSLC	Mexia State Supported Living Center
NCP	Nursing Care Plan
NEO	New Employee Orientation
NIP	Nursing Intervention Plan
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P&T	Pharmacy and Therapeutics
PA	Physician Assistant
PAP	Papanicolaou
PALS	Positive Adaptive Living Survey
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician

PEG	Polyethylene Glycol
PET	Performance Evaluation Team
PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
PIC	Performance Improvement Council
PIT	Performance Improvement Team
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PNMT	Physical and Nutritional Management Team
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy
PTA	Physical Therapy Assistant
PTSD	Post Traumatic Stress Disorder
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QHS	At bedtime
QMRP	Qualified Mental Retardation Professional
QSM	Quality Services Manager
QSO	Quality System Oversight
RD	Registered Dietician
RN	Registered Nurse
RNP	Registered Nurse Practitioner
SA	Settlement Agreement
SAM	Self-Administration of Medication
SAMT	Settlement Agreement Monitoring Tool
SATP	Substance Abuse Treatment Program
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPO	Structured Program Objective
SPOI	Supplemental Plan of Improvement

SSLC	State Supported Living Center
STOP	Specialized Treatment of Pedophilias
UA	Urinalysis
UIR	Unusual Incident Report
URC	Unified Records Coordinator