United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of Onsite Review: March 14-18, 2011

Date of Report: May 9, 2011

Submitted By: Alan Harchik, Ph.D., BCBA-D
Monitor

Monitoring Team: Helen Badie, M.D., M.P.H, M.S.
Carly Crawford, M.S., OTR/L
Jodie Holloway, M.D.
Gary Pace, Ph.D., BCBA-D
Natalie Russo, R.N., M.A.
Teri Towe, B.S.

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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 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 (SA), 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, and 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 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, at-risk procedures, and consent; Natalie Russo

reviewed nursing care; Helen Badie reviewed medical services, dental services, and pharmacy and safe medication practices; Jodie Holloway reviewed psychiatry services; Gary Pace reviewed psychological care and services, restraint, 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, recordkeeping, and quality assurance. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, at-risk individuals, and for a variety of other sections of the report.

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 might 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 review. The Monitoring Team made additional requests for documents while onsite.

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 (CLDPs), 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 onsite, 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. The recommendations for some provisions include a subsection of additional suggestions for the facility. These are presented in an effort to assist the facility in prioritizing activities as the facility staff work towards achieving substantial compliance with the provision.

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 review. The facility director, Dr. William Lowry, was, as always, supportive of the monitoring team's activities throughout the week of the onsite review. He was readily available, ensured that all requested information was obtained, and directed all of the 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. She worked tirelessly during the week of the onsite review, as well as during the weeks immediately proceeding and following the onsite review, to ensure that the monitoring team members were able to obtain the information they needed to conduct this review. Ms. Jenkins is extremely knowledgeable about the operations at MSSLC and is a valuable resource to the facility. She was assisted by Bobbie Hall and Sandra German.

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 many individuals is included in this report, providing a broad sampling from all homes and across a variety of individual needs and supports. 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 review. 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, the Settlement Agreement required the facility to complete a self-assessment, and to submit it to the Monitor 14 days prior to the onsite review. The facility did so and, in the monitoring report below, the Monitor describes and comments upon the self-assessment steps the facility undertook to self-assess compliance and the results of this self-assessment. This is provided for each of the 20 provisions of the Settlement Agreement. At MSSLC, the self-assessment document was called the POI (Plan of Improvement). The format of the POI was revised since the last onsite review and was a major and noticeable improvement from the previous more lengthy version.

Fourth, MSSLC was working to implement the many new service provision changes that were occurring across all of the DADS SSLCs. These changes included

- New PSP documents and new style PSP meetings
- New Community Living Discharge Plan activities and documents
- New assessment and management of individual at-risk procedures
- New Physical and Nutritional Management Team procedures

Fifth, as detailed in the full report below, MSSLC had made progress in some areas, but a lot of work was still required in order for the facility to achieve substantial compliance in the many provisions of the Settlement Agreement. As the reader will see below, the requirements across provision items vary greatly. Some require full organizational system actions, whereas others only require the creation of a document or the hiring of qualified staff. Below are some comments on a few general topics that affected all areas of operation at the facility.

- At-risk and aspiration: MSSLC was just beginning to implement the statewide initiative on the new at-risk policy and procedures, with a specific focus on aspiration and pneumonia issues. Implementation was not yet adequate as evidenced by meeting contents and staff interview as noted in this report (see sections F, M, and O).
- Integration of services. There was a lot of discussion and comment around the facility regarding a desire to meet the provision of integrated clinical services (see section G) and integrated individual program plans (see section F). Managers and clinicians, noted above, were already engaging in activities towards greater integration. Further work will be required to include all disciplines, and to set the occasion for disciplines to work closely together when needed (e.g., psychology and psychiatry, pharmacy and medical). The medical director had lead responsibility for the integration of clinical services (section G), however, achieving substantial compliance will require participation by all clinical departments. The monitoring team recommends that senior administration take a more active role in ensuring that the requirements of provision G are addressed in a facility-wide manner.
- Meetings. There were many meetings at MSSLC, including many PSPAs that were held to address new incidents, injuries, and changes in an individual's status. Often, meetings were called with little notice making it difficult, if not impossible, for clinical and management staff to attend to their typical day-to-day requirements. Certainly PST meetings are important and need to occur. The monitoring team suggests that this challenging problem be addressed by via QAQI Council and/or a performance improvement project.
- Engagement and activities. The facility made progress in addressing engagement and activities. Continued work on this will be especially important for the population at MSSLC. A variety of activities throughout the evenings and weekends (as well as during the week day) can provide opportunities for learning, occasions for practicing appropriate social skills, and alternatives to the occurrence of problem behaviors.
- Monitoring tools. MSSLC had modified a number of the monitoring teams' checklist monitoring tools and was using some of the tools as modified by DADS central office. These modifications made the tools more user-friendly and appropriate for use by facility staff. Additional attention will need to be made to ensure the tools are updated and that they are implemented reliably (see section E below).

Seventh, a brief summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and a full 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

- A total of 610 restraints were utilized for crisis intervention involving 100 individuals from 9/1/10 through 1/31/11. The number of restraints had decreased since the last monitoring visit. This decrease was primary due to the spike in restraint numbers in September 2010. The facility moved many individuals without developing an appropriate transition plan resulting in an increase in behavioral incidents during that time period.
- The facility had developed a new restraint review process and was providing additional training to staff involved in restraint incidents when inappropriate restraint implementation was identified. The facility gathered and analyzed data on restraints monthly and produced a monthly trend analysis that looked at restraint types, individuals and staff involved, residential units, locations of the restraints, and the days of the week/shifts when the restraints occurred.
- Routine dental work was now completed at the facility. The dental staff were focusing on strategies to reduce the need for restraint during routine dental procedures by developing desensitization strategies for individuals who required the use of restraint during dental appointments.
- To reduce the frequency of use of restraint, the facility should focus on expanding options in day programs to include a wider variety of meaningful work and recreational activities both at the facility and in the community based on individual's assessed needs and preferences.
- Inadequate documentation of restraints made it difficult to track activities that individuals were engaged in prior to the behavior resulting in restraint and learn from previous restraint incident.

Abuse, Neglect, and Incident Management

- Although not trended or analyzed, a log of all DFPS cases from FY11 1st quarter (9/1/10-12/31/10) listed 564 cases. Thirty-eight of these allegations were confirmed by DFPS (7%). Some of the cases included multiple allegations. Of the confirmed allegations, there were 16 confirmed incidents of physical abuse, 20 confirmed incidents of neglect, one confirmed exploitation allegation, and one confirmed allegation of emotional/verbal abuse. According to MSSLC's trending for FY10 4th quarter, investigation of 562 cases were conducted by DFPS from 6/1/10 through 8/31/10. Of these 562 cases, 14 (2%) were confirmed by DFPS. There was an increase in the number of allegations from FY10 3rd (345) quarter to FY10 4th quarter (562). The facility attributed this to an increase in the number of false allegations made by individuals at MSSLC.
- There were a total of 847 injuries reported during FY10 4th quarter, of which 29 were reported as serious injuries. Trends were not yet available for injuries reported during FY11 1st quarter, however, a log listed 15

serious injuries during this period. Twelve of the 44 serious injuries were attributed to aggression by peers, 15 resulted in fractures, and 19 required sutures or dermabond.

- MSSLC was fortunate to have a team of seasoned investigators that had developed a good system for dealing with the massive numbers of incidents and investigations at the facility. It was noted that behavioral issues were the underlying cause for a majority of the incidents and injuries that occurred at the facility. In order to reduce the number of incidents and injuries significantly, the facility will need to develop a comprehensive plan to restructure programming in a way that will have a greater impact on reducing behavioral incidents at the facility. It is of great concern to the monitoring team that individuals at the facility continued to be at risk for harm in their current environment at MSSLC.

Quality Assurance

- Progress had been made since the previous review and the QA department's activities appeared to be pointed in the right direction towards eventual substantial compliance. The QA director had initiated the beginnings of a QA policy, QA plan, and QA report..
- The QA department needs to take a more comprehensive approach to managing data at the facility. This includes
    - Creating a listing of all data collected at the facility that includes data collected by each service department and by QA department staff, and that is in line with the areas in the guidelines written by the Assistant Commissioner.
    - Determining which of these data are to be submitted to the QA department for tracking and trending, included in the QA report, and presented to QAQI Council.
- The facility was using a set of self-monitoring tools that were designed to be used at all of the SSLCs. The monitoring team, however, recommends that the facility and state work with the monitoring teams to review and update the state-created tools so that they are based upon the most recent findings and activities of the monitoring teams.
- Self-advocacy meetings present another way of obtaining information that may be useful to the QA department and facility management. It did not appear that MSSLC was meeting the self-advocacy needs of the individuals, as evidenced by poor attendance and participation, somewhat irrelevant topics, and absence of any teaching of problem solving and decision-making. On the other hand, residential services had recently initiated home meetings for individuals that allowed for small group discussion around issues and activities more pertinent to the individuals.
- MSSLC had an active set of Performance Evaluation Teams. During each meeting, the service department head presented updates and information regarding progress towards achieving substantial compliance as well as the results of implementation of the self-monitoring tools and the comparison to the QA department's

implementation of the same tools. Five CAPs were being implemented at the time of this onsite review. The organization and presentation of the CAPs was another improvement since the previous onsite review.

Integrated Protections, Services, Treatment, and Support

- The DADS policy for this section had been revised and approved 7/30/10. The forms and instructions relative to PSP development had been revised prior to the monitoring team's visit. QMRPs had attended training on developing person centered plans and had begun to implement the new process at annual PST meetings on 1/1/11. PST meetings observed the week of the monitoring visit were in the new style format.
- At the PSP meetings observed, team members discussed supports needed in relation to the individual's preferences and interests. The new format of the plans indicated that there were some very positive changes occurring in PSP development that would lead to individuals having plans that were useful guides to staff supporting the individual on a daily basis. Information regarding supports that the individuals needed throughout the day was more clearly stated in the newer PSPs.
- While there was positive movement towards integrating supports throughout each individual's plan, there was not much progress being made on developing plans that would lead to a more meaningful day for individuals. Teams were restricted by the lack of program options offered at the facility and very little consideration was given to programming in the community. The facility offered very few options in terms of programming. The majority of individuals at the facility either went to school or worked at one of the few jobs offered at the facility. When not in school or working they attended one or more classes offered at the facility.
- Individual's schedules were not driven by their preferences, but instead by options offered for programming at the facility. Classes were focused on either behavioral interventions identified for a number of individuals at the facility or medication administration and health education (SAM and HIP). A review of PSPs and informal interviews with individuals at the facility indicated that many were not interested in attending these classes. The monitoring team noted that many behavioral issues at the facility appeared to be a result of boredom or lack of active treatment in line with individual's preferences. The current system for developing outcomes for individuals will not be sufficient to address the person centered planning process.
- Quality enhancement activities with regards to PSPs were in the initial stages of development.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- MSSLC had made some progress in this provision area, but more work was needed. Progress was seen in the variety and breadth of activities that were occurring across the facility (G1). Numerous efforts had been taken to address the handling of non-facility clinical consultations (G2). A number of specific examples were provided

to, or observed by, the monitoring team that showed ways in which MSSLC was making service provision more integrated across clinical service departments. On the other hand, there were a number of areas in which integrated services could be, but were not being, provided.

- A draft of a state policy was reviewed. It addressed a combination of the requirements of both provisions G and H. The content related to section G, however, was merely a restating of the wording from the Settlement Agreement and will, most likely, be insufficient to guide the facility in engaging in those actions that will lead to, and demonstrate, the provision of integrated clinical services. Moreover, without additional guidance, there will be little consistency across SSLCs and little sharing of best practices. As a result, the monitoring team recommends specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring
- It will be important for the facility to include all clinical services, not only medical services, as it works towards addressing the requirements of these provisions.
- It is recommended that the facility's QA department play a role in addressing these provisions.

<u>At-Risk Individuals</u>

- The state had taken a number of steps to support positive results in the area of risk management. This included:
  - The state policy addressing risk had been revised. It was approved 12/29/10 and implementation began prior to the monitoring visit at MSSLC. The new policy included changes in evaluating and addressing risks identified for individuals.
  - Forms had been revised forms for identifying and a risk action plan to address risk had been developed.
  - Risk Guidelines had been developed to be used by PSTs in rating risk factors.
  - A new initiative was being implemented to address aspiration pneumonia. A tool had been developed to identify individuals at risk for aspiration.
- The at-risk process designated each individual's PST responsible for risk assessment and management, as well as ongoing risk review and addressing changes in status. Not only would the PST identify health and behavioral risks and their level of severity, but would assure appropriate plans were developed and implemented as planned in order to reduce risks and improve quality of life. The revised at-risk process identified collaboration and assistance with the BSC and PNMT in developing plans for individuals at high risk, who were not stable or for whom the team has requested assistance.

<u>Psychiatric Care and Services</u>

- MSSLC now had four full-time equivalent locum tenens psychiatry staff, recently contracted to provide psychiatric services. The psychiatrists were learning the system and meeting the individuals assigned to their caseload. The medical director had integrated the psychiatrists with the medical staff by their participation in

the daily staff meetings and weekly lunch meetings with the primary care physicians. The four facility psychiatrists were encouraged to meet together routinely to develop a plan to review and implement the provisions outlined in the Settlement Agreement in order to establish a psychiatric system of care that met generally accepted professional standards of care.

- There was no child and adolescent psychiatrist, forensic psychiatrist, and/or board-eligible forensic child and adolescent psychiatrist providing services at MSSLC for the minors at the facility. Minors were admitted for assessment and secondary to court commitment.
- The psychiatric clinic was not organized. Space for the psychiatric clinic had not been identified and the schedule was inconsistent, resulting in individuals not being present for their examination. The medical director, director of psychology, and the facility psychiatrists were receptive to working together to establish revisions to the delivery of psychiatric services for the individuals at MSSLC.

Psychological Care and Services

- Although only two of the items in this provision were found to be in substantial compliance, there were several improvements since the last onsite review. These included an increase in the number of staff enrolled in BCBA coursework, addition of internal and external peer review, the expansion of a simplified data system across the majority of homes, the use of more sensitive data presentation, improvements in functional assessments, the development of a new psychological assessment format for annual updates, improvements in Positive Behavior Support Plans, and discussions have begun to clarify what behavior procedures can be used at MSSLC
- Areas that are most in need of improvement are ensuring that all group and individual therapies are based on evidence-based procedures, and services are goal directed with measurable objectives and treatment expectations, ensuring that data are reliably collected, ensuring that PBSPs are implemented with integrity, systematic training of all direct care professionals in the implementations of each individual's PBSP, ensuring that all functional assessments include all the necessary assessment components and have a clear summary of the variables hypothesized to affect target behaviors, and ensuring that all Positive Behavior Support Plans are based on the hypothesized function of the target behavior, and specify clear, concise antecedent and consequent interventions.

Medical Care

- Progress was noted in the provision of medical services. Overall, individuals received appropriate routine and preventive care, although there were some deficiencies noted in areas, such as colorectal cancer screening and breast cancer screening. A comprehensive seizure management program had not been implemented, but more individuals were having outside neurology appointments. The Neurology Physician Assistant from Scott &

White had been to the facility and a follow-up phone conference was completed for one individual. This presented new treatment options for this individual with intractable seizure disorder.

- An external review was completed just prior to the onsite review and audits of records were done across the caseloads of all six physicians. This should provide valuable feedback to the primary care physicians. Mortality reviews were completed, but there continued to be concerns with implementation and follow-up of recommendations.
- Clinical guidelines were in the process of development but had yet to be implemented. Development of a medical quality program was contingent upon this process.

Nursing Care

- Since the prior monitoring review, the Nursing Department had undergone positive changes in staff members who occupied positions of leadership within the Department. Also, a number of policies and processes were reviewed and revised as part of the Nursing Department's focus on compliance with this provision of Section M.
- MSSLC's processes of identifying, reporting, evaluating, assessing, communicating, intervening, and documenting timely responses to significant changes in individuals' health needs and risks may effectively result in proper care and treatment. But, improvements were needed in order for it to become a regularly occurring, reliable method of appropriate care and treatment.
- For example, at this time, a review of documentation of Integrated Progress Notes, other reports, and meeting minutes 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.
- Current annual and/or quarterly nursing assessments were not present in five of the 30 records reviewed, and in the vast majority of records reviewed, these nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions. Thus, the nursing diagnoses drawn from the assessments and the plans developed from the diagnoses did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks.
- The administration of medication and the management of the medication administration system at MSSLC had undergone several changes since the prior monitoring review. As indicated in more detail below, additional work still needed to be done in the areas of management of the medications by the nurses and in the oversight of medication errors.

Pharmacy Services and Safe Medication Practices

- Progress was made in pharmacy services since the September 2010 onsite review. The prospective reviews of medication orders continued through the double check system. The clinical intervention log was used to document interactions between the pharmacists and physicians. Clinical intervention data was being used to improve the provision of pharmacy services and physician prescribing patterns. The leadership of the pharmacy department changed at the end of January 2011.
- The quality of the drug regimen reviews had improved substantially. Many of them had been typed to improve readability. Moreover, the reviews contained more robust information and routinely commented on monitoring parameters for psychotropic and AED use. Physicians were responding to recommendations made by the pharmacists and this was good to see. The MOSES and DISCUS tools were being completed, but work was needed in the area of making this information useful. Primary care physicians did not seem to utilize this information and none of the neurology notes reviewed captured these findings.
- Two drug utilization evaluations were completed, but considerable work was still needed in this area. There was no local policy to guide this process resulting in two DUEs that were presented in entirely different formats. The facility started reporting adverse drug reactions, but the system will require several changes in order to be clinically relevant.
- Medication variances were being reported and reviewed. Medication errors increased in part due to frequent counting and reconciliation. Even more concerning were the reports of hundreds of doses of medications that were retuned to the pharmacy on a monthly basis with no explanation for almost half of the returns.

Physical and Nutritional Management

- The PNMT process was not initiated, other than to begin to identify team members with four organizational meetings. There had been no individual-specific reviews completed and the team membership was still in question with regard to the nurse. One of the new contracted OTs was designated to participate, but had not yet completed NEO. The team was planning to transition to a full-time dedicated team because referrals increased. There will be a significant period of growth as they attempt to clearly establish roles and responsibilities. The target start date was designated as 4/1/11.
- The risk assessment process and aspiration initiatives were also new processes and will require significant and thorough review in six months. This team will need to work diligently as they serve as both the PST members and adjunct PNMT members so that they can carefully examine each case in a new manner so as to design and implement appropriate and effective intervention plans. There will be a balance of new staff (SLP and OT) as well as the relatively new director, who serves as chairperson, with existing staff and this should assist the team from this perspective.
- There continued to be implementation errors during meals, related to position and alignment, as well as assistance techniques, adaptive equipment, and diet texture and liquid consistency.

Physical and Occupational Therapy

- The Habilitation Therapies department was dealing with significant issues of transition and instability in the wake of large caseloads and the expectations related to this provision. There was a new department director, existing staff were scheduled to be transitioning out, and new staff were transitioning in.
- There was limited change noted since the previous review regarding the requirements of the items of this provision. Systems had not been modified in any essential manner. The assessment process had changed very little from the previous review. There continued to be no training objectives and the interventions provided by OT and PT were still not integrated into the PSP. There continued to be no clearly established link between the health risk indicators identified by the PSTs with the PNMPs.
- Monitoring was not clearly driven by level of risk. The PNMPCs required more training and oversight in order to ensure that monitoring provided the appropriate data to evaluate the efficacy of person-specific plans as well as the training provided to staff related to implementation of PNM. There had not been any system of trend analysis established to date.

Dental Services

- The dental clinic had made little progress overall in meeting in the items of the Settlement Agreement. This was unfortunate to note particularly since the clinic staff were committed to serving the individuals supported by the facility. This monitoring review was impeded by a lack of information needed to assist in determining compliance. For example, only six of 36 document requests were fulfilled. Other items were listed as there being "no information." Problems with management of information and data were also identified during the September 2010 onsite review. The dental director reported that he received no assistance with data generation until two weeks prior to the onsite review and he worked until 7 pm or 8 pm most days just to keep up with charting. The medical director, who supervised the dental director, reported that she was not aware that information had not been submitted.
- The dental clinic staff included the dental director, two hygienists and two dental assistants. All were long-term employees who were clearly worked in the best interest of the individuals supported by the facility.
- The clinic started collecting data on missed appointments and refusals and forwarding the data to the home managers and psychologists. The effectiveness of this was not apparent, and certainly had little impact on the development of formal desensitization plans. Oral hygiene in the homes was reported by the staff to be a problem. Many individuals returned monthly for oral care in the clinic. Additional special supports for those at high risk for aspiration were also needed.

Communication

- There was little change noted since the previous review. The speech staff reported that not all individuals who needed AAC and other communication supports and services received them. There were a small number of AAC systems in place. Approximately 32.5% (132/405) of the individuals listed in the Master Plan were identified as nonverbal. The POI reported that only one individual had a high tech communication device, 12 were provided light tech communication devices, and 14 individuals were provided low tech communication devices.
- There was generally a very limited focus on expansion of communication skills or new skill acquisition. There were no home or classroom-based SPOs recommended and trials for training AAC for five individuals were not integrated into the PSP via measurable goals.
- During observations, devices were not observed in use. Staff did not appear to understand how to use these in programming or functionally throughout the day. Direct support staff and classroom instructors were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred in order to promote communication skill acquisition. A focus on activities designed to promote actual participation, making requests, and other communication-based activities, using assistive technology, is critical. This will require that the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts.
- Another significant concern involved those individuals who may have been more verbal or partially verbal, but exhibited significantly maladaptive behavior that had a foundation in their difficulty with communication skills. These individuals may not be viewed as a priority related to their communication risks, however, significant problem behaviors emphasized the necessity for a strong collaborative approach by PSTs, led by psychology and speech clinicians, in order to develop effective interventions to address these needs.

<u>Habilitation, Training, Education, and Skill Acquisition Programs</u>

- This provision incorporates skill acquisition, engagement in activities, and staff training. 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. There were several improvements since the last review. These included systematic collection and analysis of individual engagement, development of an SPO monitoring tool, and the systematic analysis of associated data, modification of skill acquisition plans, improvement in the documentation of the rationale for SPO selection, development of a data system to track and improve training of individuals in the community, and improved individual engagement scores.
- At the same time, the facility is reminded that the collection and analysis of data is a tool for achieving the ultimate objective which is too ensure that all individuals are engaged in meaningful activities, and that SPOs are consistently practical and functional.

Most Integrated Setting Practices

- MSSLC continued to engage in many activities to encourage and assist individuals to move to the most integrated setting. The number of individuals placed in the community had decreased over the past year. The facility director noted that this was due to the facility implementing a slower and more conservative process in making placements. This was a sensible way to approach placements, given the complex needs of most of the individuals referred for placement.
- There were problems, however, with a number of MSSLC placements over the past year. Although they were a small percentage of the total number of community placements made by the facility, each one should be thoroughly reviewed and studied so that similar problems might be avoided in the future. This is especially important because, given the challenging and complex histories of many of the individuals being placed by MSSLC, a single failed community placement could have a chilling effect on the facility's (and DADS') ability to place individuals (e.g., if there is an injury to an innocent member of the community).
- The opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required (this was what was noted in the previous monitoring report). Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility.
- Fourteen CLDPs were reviewed and were found to be surprising similar, if not identical. The lack of individualization, especially in the listing of essential and nonessential supports was a serious problem. Further, the lists of supports in the CLDPs were inadequate. Problems in identifying essential and nonessential supports were identified in the baseline monitoring report and again the previous monitoring report. Almost every individual had only two or three essential supports and they were almost identical in every case. Most of the supports required the provider to be trained on aspects of the individual's care (e.g., PBSP, PNMP), but failed to list the important components as separate supports. The required evidence did not include detail that would allow the PMM to determine the adequacy of its provision.
- The MSSLC placement process, however, was not without some positives. MSSLC continued to place a large number of individuals, individuals were placed from all units at the facility representing all ages and functioning levels, individuals had opportunities to select from different providers and go on overnight visits, and typically, there were multiple PSPA meetings leading up to the final CLDP meeting prior to move.
- The post-move monitoring was completed within the required timelines. All of the completed checklists followed the requirements of Appendix C of the Settlement Agreement. Post-move monitoring did not always involve onsite visits and observations at both the day and residential sites. The APC planned for this to happen, given the new state policy and practice expectations. Problems with post move monitoring paralleled those noted in the development of the list of essential and nonessential supports discussed in detail in section T1e. In

some of the forms, the PMM indicated serious questions regarding the intent of the PST because of the vague descriptions of supports, and vague or absent descriptions of how to assess presence or absence. Moreover, there was very little narrative in the completed forms. In addition, the specific criterion for each support was not indicated.

Consent

- MSSLC indicated it was waiting on the final statewide policy and training before taking most actions. The facility did not maintain a prioritized list of individuals needing an LAR. Not all PSTs were adequately addressing the need for an LAR or advocate. The facility was not actively pursuing guardianship for individuals at MSSLC.

Recordkeeping and General Plan Implementation

- MSSLC had made a lot of progress towards achieving substantial compliance with the items of this provision. 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. The new set of records followed the state's policy. A facility-specific policy was written and was submitted to DADS central office for review and approval. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record. The nursing section, however, was very large and consideration should be given to either reducing the size or subdividing so that it is more manageable for all staff. Further, It would be helpful for there to be information as to what consents are appropriate and required for each individual, and an indication of what medical consultations should be in each individual's record. The medical director maintained a listing of all medical consultations. This listing might be useful to the recordkeeping department in this regard.
- Individual notebooks were also in place for each individual, however, MSSLC managers and clinicians reported many problems in using the individual notebooks in most of the units. The issues were primarily around the cumbersome and somewhat counter-therapeutic characteristics of the notebooks. A determination will need to be made as to whether the individual notebooks can be eliminated. If so, the facility will need to ensure that the original intentions for creating the individual notebooks are met via other processes.
- The conduct of quality assurance reviews of the unified record was another area where continued improvement occurred since the last review. Thorough reviews of active records were conducted by the unified records coordinators. Moreover, unit record clerks were required to conduct reviews, too. The URCs developed and maintained a system to list, manage, and follow-up on all corrections that needed to be made following each review. The master record, however, was not yet part of the review process.
- MSSLC had begun to look at ways to determine whether and how the unified records were used in making treatment decisions as specified in provision V4. The director of client records had been talking with the

recordkeeping staff at San Antonio SSLC to pilot some of their procedures. This was good to see. It is likely that, ultimately, a set of activities will be required in order to meet the requirements of V4.

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 MSSLC Use of Restraint Policy dated 9/3/10 o MSSLC Psychological Services Policy dated 4/12/10 o MSSLC Suicide Precautions Policy dated 1/31/11 o List of all restraints for the past six months o List of all chemical restraints 8/1/10 – 2/12/11 o List of pretreatment sedation restraints 8/1/10-2/14/11 o Restraint documentation for the last six months for the three individuals with the highest number of restraints o The facility's "Do Not Restrain" list o Dental desensitization plans for: ▪ Individual #481, Individual #335, Individual #456, Individual #369, Individual #196, Individual #500, Individual #564 o Restraint Reduction Committee meeting minutes 9/16/10 – 1/31/11 o List of restraint related injuries 1/1/10 – 1/27/11 o MSSLC restraint trending for FY11 o List of all individuals who had a Safety Plan o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities o Unit meeting notes from 10/1/10 – 1/31/11 o PMAB Training Curriculum o Training transcripts for 24 MSSLC employees o A list of employees delinquent in PMAB recertification o Human Rights Committee meeting minutes from the last six months o Incident Management Review Team Meeting Minutes o Positive Behavior Support Plans, Safety Plans, and PSPAs for: • Individual #177, Individual #6, Individual #365, Individual #519, Individual #113, Individual #367, Individual #441, Individual #491, Individual #591, and Individual #508 o Functional Assessments for: • Individual #519, Individual #441, and Individual #491

- A sample of restraint documentation including:

Individual	Date/Type	Restraint √list Face to Face Debriefing	PSP	PSP Addendum(A)	PBSP		Safety Plan
#48	2/11/11 Physical	X		2/15/11			
#153	2/10/11 (3) Physical	X		2/10/11 2/11/11			
#6	11/17/10 Chemical	X	4/20/10		4/20/10		7/12,
#268	2/11/11 Physical	X					
#543	2/13/11 Physical	X	4/12/10		4/15/10		
#287	12/1/10 (2) Physical	X	6/10/10	12/2/10	6/10/10		
#359	12/21/10	X			6/1/10 Safety Plan 6/4/10		
#483	2/11/11 Physical 1/15/11 (3) Physical 1/8/11 Physical (2) 1/3/11 Physical 11/17/10 Physical 11/8/10 Physical 10/12/10 Physical 10/6/10 Physical 9/30/10 Physical	X X X X X X X X X	3/29/10		3/29/10 Safety Plan 5/3/10		5/3/1
#365	1/1/11 Physical 12/24/10 Physical 12/21/10 (3) Physical 10/14/10 Physical 8/28/10 Physical 8/27/10 Physical	X X X X X X					
#491	2/14/11 (2) Physical 2/5/11 (5) Physical 2/5/11 Chemical 1/24/11 Physical 1/18/11 Physical 12/16/10 Physical 12/10/10 Physical 12/8/10 Physical 10/3/10 Physical 9/29/10 Physical	X X X X X X X X X X	2/3/10		1/6/11 Safety Plan 1/1/11		

	9/21/10 Physical 9/17/20 Physical	X X					
#303	1/28/11 Medical pretreatment sedation		4/19/10	1/31/11	4/19/10		
#422	1/24/11 1/31/11 Medical pretreatment sedation		6/8/10	1/25/11 2/1/11	6/11/10		
#388	2/3/11 Dental sedation		2/16/10		2/16/10		
#494	1/25/11 1/26/11 Medical pretreatment sedation			1/25/11 1/26/11			

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs;
- Charlotte Kimmel, PhD, Director of Psychology
- Valerie McGuire, QMRP Director

Observations Conducted:

- Observations at residences and day programs
- Daily Incident Management Review Team Meeting 3/14/11 and 3/15/11
- Behavioral Therapy Committee Meeting 3/14/11
- Restraint Reduction Committee Meeting 3/16/11
- Human Rights Committee Meeting 3/15/11
- Shamrock Unit Meeting 3/15/11
- Quarterly PST meeting for Individual #225
- Annual PSP meetings for Individual #374 and Individual #413

Facility Self-Assessment:

The facility's Plan of Improvement for section C indicated that the facility was not in compliance with the provision items in Section C. The monitoring team agreed with the facility's compliance assessment. The facility has taken positive steps towards compliance as noted throughout section C of this report.

	Summary of Monitor's Assessment: Information submitted to the monitoring team regarding restraint incidents indicated that the number of restraints implemented by month had decreased since the last monitoring visit. A list provided to the monitoring team showed a total of 610 restraints were utilized for crisis intervention involving 100 individuals from 9/1/10 through 1/31/11. Some areas where the monitoring team saw positive progress in addressing section C of the Settlement Agreement included: • The facility had a decrease in the number of restraints over the last six months. This decrease was primary due to the spike in restraint numbers in September 2010 and October 2010. The facility moved many individuals without developing an appropriate transition plan resulting in an increase in behavioral incidents during that time period. • The facility had developed a new restraint review process and was providing additional training to staff involved in restraint incidents when inappropriate restraint implementation was identified. • The facility had gathered and analyzed data on restraints monthly and produced a monthly trend analysis that looked at restraint types, individuals and staff involved, residential units, locations of the restraints, and the days of the week/shifts when the restraints occurred. • The facility continued to focus on the reduction and avoidance of the use of restraints. • Routine dental work was now completed at the facility. The dental staff were focusing on strategies to reduce the need for restraint during routine dental procedures through evaluating the past use of restraints and developing desensitization strategies for individuals at the facility who required the use of restraint during dental appointments. The facility indicated that it continued to focus upon restraint reduction. In particular, the psychology department reported to the monitoring team that restraint reduction was an ongoing focus at the facility. Two areas were identified by the monitoring team during the review week that will be essential in reducing restraints incidents at the facility. 1. Consistent alternative behavioral strategies for crisis intervention need to be clearly stated. Staff should be trained to implement alternative behavioral strategies for individuals who they support. The effectiveness of strategies needs to be monitored and strategies revised when not effective. 2. The facility should focus on expanding options in day programs to include a wider variety of meaningful work and recreational activities both at the facility and in the community based on individual's assessed needs and preferences. As discussed further in C1 below, inadequate documentation of restraints made it difficult to track activities that individuals were engaged in prior to the behavior resulting in restraint and learn from previous restraint incident.

#	Provision	Assessment of Status	Compliance
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 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.	Based on information provided by the facility in a list of all restraints used for crisis intervention, between 9/1/10, and 1/31/11: • 100 individuals were the subject of restraints, • 620 restraints occurred, • 2 (<1%) of these were mechanical restraints o These two mechanical/protective restraint incidents involved the use of mittens for two individuals with self-injurious behavior, • 589 (95%) of these were physical holds, • 29 (5%) of these were chemical restraints, • 241 (39%) of these were emergency restraints, and • 379 (61%) of these were programmatic restraints (i.e., part of a safety plan). The facility provided a list of medical pretreatment sedation and restraints between 8/1/10 and 2/14/11: • 37 individuals were the subject of restraints, • 76 incidents of restraint occurred, • 40 of these were pretreatment sedation for medical appointments, and • 36 of these were the use of mittens to prevent injury or promote healing. The facility indicated that there had been no incidence of dental pretreatment sedation in the past six months. A list provided by the facility identified eight individuals with written dental desensitization plans in place. <u>Prone Restraint</u> Based on facility policy review, prone restraint was prohibited. Based on review of other documentation, including a list of all restraints and a sample of restraint checklist, prone restraint was not identified. A sample, referred to as Sample #C.1, was selected. This included nine individuals and was selected to ensure that some of the individuals with the highest numbers of restraint were included. The individuals in this sample included Individual #48, Individual #153, Individual #6, Individual #268, Individual #543, Individual #287, Individual #483, Individual #365, and Individual #491. Based on a review of 46 restraint records for individuals in Sample #C.1 involving nine individuals, 0 (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> Based on document review, the facility policies stated that restraints may only be used if	Noncompliance

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		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. Restraint records were reviewed for Sample #C.1 that included 46 restraint checklists (a sample of the restraint checklists for nine individuals), face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In 46 of the 46 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • Aggression towards staff and/or peers or self-injurious behavior was indicated as the reason for the restraint on all forms that described behavior leading to the event. • For the 46 restraint records in the sample, a review was completed of the description of events leading to behavior that resulted in restraint. A majority of the checklists reviewed described the individual's behavior prior to the restraint, but not all described events leading up to or causing these behaviors. Seven of the checklists (15%) did not give a brief description of events that occurred prior to the restraint. This information would be useful for direct care staff and clinicians to know to avoid future restraint incidents. Examples of good documentation included: o The restraint checklist for Individual #491 dated 12/16/10 indicated that she was talking with a staff person when a peer told her to "go to her room." The individual then ran into the living room and grabbed the other individual by the hair. o The restraint checklist for Individual #483 dated 11/17/10 indicated that he was calm throughout the day, but while in the shower, he had an outburst. o The restraint checklist for Individual #483 dated 9/30/10 indicated that he was in the restroom using the toilet when he suddenly jumped up and began biting his wrist. o The restraint checklist for Individual #543 dated 2/13/11 indicated that he was in an altercation with another individual prior to the restraint incident. Examples where this was not the case included: o In the area for the description of events on the restraint checklist for Individual #483 on 1/8/11, staff documented "suddenly grabbed his left arm and began to bite." There is no indication what was occurring prior to the self-injurious behavior. o On the restraint checklist for Individual #483 dated 1/15/11 the	

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		description of event leading to the behavior noted that the individual began to growl and bite his wrist. Staff did not document what activity the individual was involved in at the time of the incident. o On the restraint checklist for Individual #268 dated 2/11/11, staff did not indicate what precipitated the individual's behavior that necessitated restraints. • In 32 of the records (70%), staff documented that restraint was used only after a graduated range of less restrictive measures had at least been attempted or considered in a clinically justifiable manner. Thirteen restraint checklists in the sample indicated that verbal prompts were the only intervention attempted prior to restraint. The restraint checklist for Individual #287 dated 12/1/10 did not indicate that other interventions were attempted prior to the implementation of a chemical restraint, however, following the onsite review, the facility reported that the chemical restraint consult by the psychologist stated the following alternative interventions were attempted: person was moved to another area, three staff that the individual usually responds to positively intervened, negotiation was attempted, and the psychologist tried to talk with the individual and attempted to guide the individual to a safer area. It was not clear that all restraints used were the least restrictive intervention necessary. Without good documentation of what preceded the behavior, it was difficult to identify whether adequate steps had been taken to address the behavior before the restraint was applied to allow a determination to be made that the procedures were the least restrictive necessary. It was also not evident that restraints were not used in the absence of, or as an alternative to, treatment. Although as noted above, documentation did not always indicate what activities individuals were involved in prior to restraint, only one restraint checklist reviewed indicated that the individual was actively engaged in programming based on their interest at the time of restraint. PSPs offered little guidance on engagement of individuals throughout the day and ensuring that individuals had opportunities to engage in preferred activities. Some examples where it was not evident that adequate programming and treatment were implemented prior to restraint incidents included: • For Individual #365, his PSP noted that listening to music was a priority for him. His BSP stated that his aggressive outburst peaked when his mother could no longer afford to purchase headphones for him. His restraint episodes were related to rage demonstrated over not having headphones or batteries for his radio. He was expected to work at the workshop on campus to demonstrate his compliant behavior, but there was no indication that his attendance at work	

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		would result in having the opportunity to go into the community and purchase headphones or batteries for his radio. Instead, his BSP included a point reward system for demonstrating compliant behavior so that he could purchase pens, pads, inexpensive watches, hats, sunglasses, and key chains that were stocked in the psychologist's office. • For Individual #6, a chemical restraint was administered on 11/17/10 after becoming aggressive towards staff. The restraint documentation indicated that he had refused medication for 16 days prior to the incident. It was not evident that the PST had met to discuss medication refusals or alternative treatment prior to the restraint incident. Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 47 restraints, 46 (98%) were documented as approved restraints techniques. Although restraint checklists in the sample indicated that all were techniques approved by the facility policy, the following were examples where review of restraints indicated that the restraint did not follow facility policy. • A restraint checklist for Individual #359 indicated that the restraint was implemented after the individual displayed aggressive behavior placing staff at serious risk for harm. A resulting DFPS investigation found that the restraint was unnecessary and did not follow facility policy. • A restraint assessment for Individual #543 dated 2/13/11 indicated that the restraint was not applied correctly. There was no corrective action documented for staff involved in the restraint. • The restraint review documentation for Individual #365 dated 12/21/10 noted that a hold not taught during PMAB training was utilized by staff. The staff person was referred for a PMAB refresher course. The facility was not in compliance with this provision item. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint and document all interventions attempted prior to restraint. As noted throughout this report, it was not evident that adequate treatment and programming was being consistently implemented that might reduce the number of behavioral incidents leading to restraint.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the eight individuals in Sample #C.1, where physical restraint was used, were reviewed. Of these, eight of the individuals had a Safety Plan that defined the use of restraint. A sample of restraint documentation was reviewed for the following individuals to determine if the individual was released from restraint according to criteria set forth in the Safety Plan: • For Individual #365, his Safety Plan included instructions to release him from	Substantial Compliance

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		restraint when he was quiet and not struggling. Of eight restraint incidents reviewed, six (75%) indicated that the individual was released from restraint according to the criteria set forth in the Safety Plan of release at 10 minutes. The restraint monitor did not recognize this discrepancy in release criteria in the review of the six restraints. In two instances (25%), according to documentation, he was released in less than 10 minutes when he was no longer an immediate or serious risk to himself or others. • For Individual #483, his Safety plan stated that he should be released from restraint when he was calm and was no longer a danger to himself or others. Of 12 restraint incidents reviewed, 12 (100%) indicated that he was released from restraint when he was calm and no longer an immediate or serious risk to himself or others. The restraints in the sample lasted from three to 30 minutes in duration. Documentation of the restraint lasting 30 minutes did not indicate behavior exhibited during the restraint prior to his release at 30 minutes. o For Individual #491, her Safety Plan stated that she should be released from restraint when she had ceased to struggle for five minutes. Of 11 restraint incidents reviewed, 10 (90%) indicated that she was released from restraint when she was calm and no longer an immediate or serious risk to himself or others by using the code "P" in the Action/Release section of the restraint checklist. None of the restraint checklists indicated that she was required to remain calm for five minutes as required by her Safety Plan. The restraint checklist dated 9/17/10 indicated that she was calm at 1:35 pm but was not released until 1:35 pm. A restraint checklist dated 9/21/10 indicated that she was released when no longer an immediate risk, but there were no notations prior to 32 minutes after the restraint was initiated to indicate that she was not calm at an earlier point.	
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	The facility's policies related to restraint are discussed above with regard to Section C.1. Review of the facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: • Policies governing the use of restraint, • Approved verbal and redirection techniques, • Approved restraint techniques, and • Adequate supervision of any individual in restraint. Sample #C.2 was selected from a current list of staff. This sample included 24 current employees at the facility. A review of training transcripts, including their hire dates, and the dates on which they were determined to be competent with regard to the required	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	restraint-related topics, showed that • Twenty-four of 24 (100%) had current training in RES0105 Restraint Prevention and Rules. o Four of the 24 (17%) staff did not complete the refresher training within 12 months of the previous training. • Twenty-four of 24 (100%) had completed PMAB training within the past twelve months. o Five of the 24 (21%) did not complete refresher training within 12 months of previous restraint training. The facility provided the monitoring team with a list of employees who were delinquent in PMAB recertification training. This list included 23 employees. The facility needs to ensure that employees complete training on the all elements of restraint use at least every 12 months. The facility is, therefore, not in compliance with this provision item.	
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.	Based on a review of 46 restraint records (Sample #C.1), 46 (100%) indicated that restraint was used as a crisis intervention. Facility policy did not allow for the use of restraint for reasons other than crisis intervention. All staff were trained that restraint should only be used as a "last resort" measure. There were postings in most homes and day programs reminding staff that restraint should be used as a "last resort" intervention. Restraints, however, can be ordered for medical reasons and for pretreatment sedation. According to the "Do Not Restrain" list maintained by the facility, none of the individuals in the sample had "Do Not Restrain" orders in place regarding the restraint type documented. The "Do Not Restrain" list was posted in homes throughout the facility. While the facility had begun to focus on the reduction of restraints necessary to complete dental treatment, there was no evidence that a similar focus was occurring in regards to restraint utilized to complete medical treatment. Plans reviewed during the monitoring visit did not address strategies to reduce the use of medical restraints. The facility did identify individuals for whom dental restraint had been historically used and the dental staff were evaluating the use of restraint for each individual at the facility. Attempts were being made to complete routine dental work without the use of restraint and desensitization programs were being implemented for those who had needed pre-sedation or restraint to have work completed in the past.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility will need to develop a system to track the use of restraints used to complete medical treatment to ensure that teams have discussed restraint use and developed desensitization plans to try to reduce the use of restraint. The facility is not in compliance with this provision.	
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 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.	Review of facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. This training was competency-based. Based on a review of 46 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 46 out of 46 incidents of restraint (100%), there was assessment by a restraint monitor. • In 43 out of 43 instances of physical restraint (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. • In 43 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • In 43 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. Based on a review of 46 behavioral restraint records for restraints that occurred at the facility there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in 40 (87%) of the instances of restraint. Restraint records where this did not occur as required included: o The restraint checklist for Individual #543 on 2/13/11 indicated that the assessment by the nurse did not occur until 55 minutes after the restraint was initiated. o Two restraint checklists for Individual #153 on 2/10/11 indicated that the assessment by the nurse did not occur until over three hours after the restraints were initiated. o The restraint checklist for Individual #268 on 2/11/11 indicated that the assessment by the nurse did not occur until 45 minutes after the restraint was initiated. o The restraint checklist for Individual #287 on 12/1/10 indicated that the assessment by the nurse occurred prior to the restraint. There was not monitoring by a nurse during or following the restraint. o The restraint checklist for Individual #483 on 1/8/11 at 3:55 pm did not indicate that the individual was assessed by a nurse following the	Noncompliance

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		restraint. • Monitored and documented vital signs in 44 (96%). Records that did not contain documentation of this included: o The restraint checklist for Individual #483 on 1/8/11 at 3:55 pm did not indicate that the individual was assessed by a nurse following the restraint. o The restraint checklist for Individual #48 on 2/11/11 indicated that the nurse attempted to monitor her vital signs on time following the restraint and the individual refused. No further attempts by the nurse were documented. • Monitored and documented mental status in 45 (98%). Records that did not contain documentation of this included: o Individual #483 on 1/8/11 Based on a review of seven pretreatment sedation for medical restraint records there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint for a minimum of two hours in 0 (0%) of the instances of restraint. Restraint records where this did not occur as required included: o The restraint checklist for Individual #303 on 1/28/11 indicated that the assessment by the nurse did not occur until two hours and 15 minutes after the restraint was initiated. No additional follow-up assessment was documented on the restraint checklist. The physician's order did not specify the schedule and type of monitoring. o The restraint checklist for Individual #422 on 1/24/11 indicated that an assessment was completed by the nurse prior to administration of the restraint, one hour and 25 minutes following administration, and nine hours later. The physician's order did not specify the schedule and type of monitoring. o Another medical pretreatment sedation restraint checklist was completed for Individual #422 on 1/31/11. It did indicate that her vital signs were monitored by the nurse, but not every 30 minutes from initiation of the restraint. o The restraint checklist for Individual #388 dated 2/3/11 indicated that the nurse completed one assessment of the individual's vital signs four hours and 55 minutes after the restraint was administered. No further monitoring was documented on the restraint checklist. o The restraint checklist for Individual #494 dated 1/26/11 indicated that she refused to have her vital signs checked when attempted two hours following the administration of a chemical restraint. Another attempt	

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		was not documented until five hours and 50 minutes after the restraint was administered. o Another pretreatment sedation restraint was administered for Individual #494 on 1/25/11. Documentation indicated that the nurse checked her vital signs four hours and 40 minutes after the restraint was administered. Monitoring and post restraint review should be consistently documented on the restraint checklist. Not all restraints were being assessed or monitored as required by this provision. The facility was rated as being in noncompliance with this provision item.	
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.	A sample of 46 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: • In 45 (98%), continuous one-to-one supervision was indicated as having been provided. One checklist for Individual #491 on 10/3/10 did not indicate level of supervision provided on the restraint checklist. • In 46 (100%), the date and time restraint was begun were indicated. • In 46 (100%), the location of the restraint was indicated. • In 39 (84%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. All of the restraint checklists described the behavior that was occurring, but seven did not indicate what events were occurring that might have led to the behavior. • In 46 (100%), the specific reasons for the use of the restraint were indicated. • In 46 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 46 (100%), the names of staff who applied/administered the restraint was recorded. • Observations of the individual and actions taken by staff while the individual was in restraint for 43 physical restraints were recorded, including: o In 42 (98%), the observations were documented every 15 minutes and at release. o In 39 (91%), the specific behaviors of the individual that required continuing restraint were recorded. • In 45 (98%), the level of supervision provided during the restraint episode was indicated. • In 44 out of 44 (100%) of physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 44 (96%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health	Noncompliance

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		effects were recorded. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. In a sample of 46 records (Sample #C.1), restraint debriefing forms had been completed for 46 (100%). A sample of six individuals subject to medical restraint was reviewed and in 0 (0%), there was evidence that the monitoring had been completed as required. See section C.5 for details of this finding. A sample of three individuals who were the subject of a chemical restraint was reviewed. In three (100%) of three restraints, documentation indicated that prior to the administration of the chemical restraint, the psychiatrist was contacted to assess whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Monitoring of restraints as required should be documented on the restraint checklist for each restraint incident and is required in order for the facility to achieve substantial compliance.	
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 MSSLC documentation, during the six-month period prior to the onsite review, a total of 19 individuals were placed in restraint more than three times in a rolling thirty-day period. Ten of these individuals (53%) were reviewed to determine if the requirements of the Settlement Agreement were met (i.e., Individual #177, Individual #6, Individual #365, Individual #519, Individual #113, Individual #367, Individual #441, Individual #491, Individual #591, and Individual #508). PBSPs, safety plans, functional assessments, and personal support plan addendums (PSPAs) were requested and reviewed for all individuals. Functional assessments were only available for three (Individual #519, Individual #441, and Individual #491) of these individuals (30%). The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. This item was rated as being in noncompliance because none of the PSPAs reviewed (0%) reflected an adequate review of the environmental, antecedent, and consequent variables that affected the behaviors that provoked restraint. It is recommended that PSPA meetings be organized so as to ensure that each of the issues below are discussed and documented. Finally, in order to achieve compliance with this item, MSSLC needs to document that each individual's PBSP has been implemented with integrity, that specific procedures for training replacement behaviors for behaviors that provokes restraint has	Noncompliance

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		been developed, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent).	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	One (Individual #508) of the 10 PSPAs minutes reviewed (10%) reflected a discussion of his adaptive skills, or biological, medical, or psychosocial factors affecting the behaviors provoking restraints. Each individual's PSPA should reflect a discussion of role of these issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them should be included. Some PSPAs reflected a discussion of these factors, but did not fully document the role they were playing or how they would be addressed. For example, Individual #177's PSPA minutes stated that he had post-traumatic stress disorder, but how this psychosocial factor affected his dangerous behaviors was not documented. Individual #177's psychological condition may be an important precursor of the behavior provoking his restraint, however, if it was hypothesized to be an important factor, the discussion in the PSPA would need to include how this factor potentially affected his dangerous behavior that provoked restraint, and a recommendation to address the condition. One of the PSPAs did reflect a discussion of relevant medical/psychosocial factors affecting the behaviors provoking restraints. Individual #508's PSPA minutes reflected a discussion that hypothesized that his need/desire for cigarettes may be related to his increase in physical aggression and restraints. The minutes also reflected a plan to address the hypothesized biological contribution to the dangerous behavior. That is, a decision was made to pay Individual #508 daily so that he could buy cigarettes daily.	Noncompliance
	(b) review possibly contributing environmental conditions;	Three of the 10 PSPAs reviewed (30%) reflected a discussion of possible contributing environmental factors to the behavior or behaviors provoking restraint. For example, Individual #491 and Individual #508's PSPAs documented a discussion of the possible role of each individual's job in contributing to physical aggression that resulted in restraint. Each Individual's PSPA also reflected a suggestion to offer different jobs. All PSPAs should reflect a discussion of possible contributing environmental factors, and suggestions for modifying them to prevent the future probability of restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item is concerned with a review of antecedents that may affect the behavior provoking restraints. Examples of issues discussed here could be the role of antecedent conditions, such as placing demands, or the presence of novel or unfamiliar staff. This discussion should also discuss how relevant antecedent conditions would be removed or reduced (e.g., the elimination or reduction of demands placed).	Noncompliance

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		None of the PSPAs reviewed (0%) included a review or discussion related to antecedents or potential structural assessments of the behavior provoking restraints.	
	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. Possible functions of dangerous behavior that could be discussed here are escaping demands or accessing desired activities. This discussion should also include how these functions will be addressed to prevent restraints in the future. For example, if it is hypothesized that escape is maintaining physical aggression, then a discussion of how to ensure that physical aggression does not result in escape should be reflected in the PSPA minutes. None of the PSPA minutes reviewed (0%) reflected a discussion of the functions of the behavior provoking restraints.	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 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;	All 10 individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Ten (100%) were based on the individual's strengths, • Seven (70%) specified the objectively defined behavior to be treated that led to the use of the restraint (Individual #508, Individual #591, and Individual #441's definitions of dangerous target behaviors were not operational), • Ten (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiated the use of the restraint (the specific method for teaching the alternative behaviors, however, was not present in any of the plans), and • Five (50%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. Four of the 10 PBSPs (40%) to weaken or reduce the behaviors that provoked restraint, however, were determined to be inadequate (i.e., Individual #177, Individual #367, Individual #591, and Individual #365) because they did not contain clear, precise interventions based on a functional assessment (see K9). The 10 Safety Plans of the individuals in the sample were reviewed. The following represents the results: ▪ In all 10 of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In none (0%) of the safety plans reviewed, was the maximum duration of restraint authorized specified; • In all (100%), the designated approved restraint situation was specified; and • In all (100%), the criteria for terminating the use of the restraint were specified.	Noncompliance

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	(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	For none of the individuals reviewed (0%) was integrity data available demonstrating that the PBSP was implemented with a high level of treatment integrity (see K4 and K11 for a more detailed discussion of treatment integrity at the facility).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	There was no evidence in the PSPA minutes reviewed, or PBSPs of these 10 individuals, indicating that any individual's PBSP was modified (when necessary) to decrease the future probability of an individual being restrained. The PSPA minutes for Individual #508 did specify that his interval of pay would be increased (to decrease the likelihood he would be without cigarettes and therefore less likely to engage in dangerous behavior), however, subsequent PSPA meeting minutes indicated that this modification was not implemented (no reason was given).	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.	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, Behavioral Therapy Committee (BTC) meetings, Daily Incident Management Team (DIMT) meetings, Daily Unit meetings, and Human Rights Committee (HRC) meetings. Observation of the Daily Incident Management Team (DIMT) meeting confirmed that restraint incidents were reviewed by the team the following working day. Restraint incidents were reported to the DIMT and referred to the PST for follow-up. PSTs met following restraint incidents to review restraints, but as noted in section C7, supports and prevention strategies developed by teams were often not consistently implemented and revised when not effective. A sample of documentation including Restraint Checklist, Face-to-Face Debriefing and Review Forms, and PSPAs related to 15 incidents of non-medical restraint was reviewed by the monitoring team. The sample included a sample of restraints for Individual #153, Individual #287, Individual #491, Individual #48, Individual #543, and Individual #365. This documentation showed that: • In 15 (100%), review by the PST and DIMT was documented in the restraint incident documentation. As noted throughout Section C, restraint documentation was often inadequate for	Noncompliance

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		determining circumstances of the restraint. One (9%) of the Restraint Review forms in the sample indicated errors or incorrect procedures in documentation, application, or monitoring of the restraint. • The restraint review documentation for Individual #365 dated 12/21/10 noted that a hold not taught during PMAB training was utilized by staff. The staff was referred for a PMAB refresher course. The facility developed a review process that includes identifying problems with restraint application and monitoring procedures and developing a plan to address any deficiencies identified. According to the director of psychology, a sample of restraint incidents were reviewed with staff implementing the restraint and retraining was provided when needed. The facility needs to demonstrate that strategies to avoid/reduce restraints are developed and monitored for effectiveness by PSTs following restraint incidents.	

Recommendations:

1. The facility needs to look at engagement levels for individuals frequently restrained for self-injurious or aggressive behaviors and develop plans to increase engagement levels in preferred activities when indicated.

2. Ensure that all staff are trained on accurately completing restraint documentation.

3. The facility needs to develop a plan to ensure that monitoring and post restraint reviews of vital signs are conducted as required and documented consistently.

4. Physician's orders for medical restraints should specify the type and frequency of monitoring required.

5. Include specific desensitization strategies in PSPs for individuals who require restraints for routine medical appointments. Monitor and document progress on plans and modify plans as necessary.

6. When restraints are not applied, monitored, or documented correctly, the restraint monitor should include this information in the follow-up assessment. Develop a plan of correction to address any deficiencies noted in the review of restraints. Continue to monitor restraints and retrain staff as necessary.

7. Follow all requirements as per C7 regarding actions required after more than three occurrences of restraint within any rolling 30-day period.

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 DADS Policy: Incident Management #002.2, dated 6/18/10 o MSSLC Policy: Incident Management dated 2/17/11 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o MSSLC Policy: Abuse and Neglect dated 2/17/11 o MSSLC Policy: Targeted On-Duty Staffing Ratio o DFPS Criteria for Establishing a Pattern of Spurious Allegations o Incident Management Committee meeting minutes for each Monday of the past six months o Daily Unit Meeting minutes for 10/1/10-1/31/10 o Log of follow-up action completed to address recommendations from investigations o Log of follow-up action not completed to address recommendations from investigations o Three most recent five-day status reports o Training transcripts 24 employees o Acknowledgement to report abuse form for a sample of 24 employees o Acknowledgement to report abuse for all employees hired in the past two months o Training and background checks for the last three employees hired o Training transcripts for facility investigators (five) o Training transcripts for DFPS investigators (eleven) o Spreadsheet of all current employees results of fingerprinting, EMR, CANRS, NAR, and CBC if a fingerprint was not obtainable o Results of criminal background checks for last three volunteers o List of applicants who were not hired based on background checks o List of background checks that led to employee termination o A sample of acknowledgement to self report criminal activity for 24 current employees o List of peer-to-peer aggression incidents for the last year o List of all serious injuries for the past year o List of Injuries by individual since 1/1/10 o A sample of 60 Client Injury Reports, including: • Individual #514, all injuries since 12/1/10 • Individual #492, all injuries since 12/1/10 • Individual #508, all injuries since 12/1/10 • Individual #225, all injuries since 12/1/10 o Log of all ANE allegations since 1/1/10 including case disposition log of employees reassigned due to ANE allegations o PSPs for

- Individual #132, Individual #40, Individual #228, Individual #113, Individual #175, Individual #548, Individual #251, Individual #497, Individual #351, and Individual #226.

o PSPs and PSPAs since 10/1/10 for four individuals with the highest number of injuries including:
- Individual #514, Individual #492, Individual #508, and Individual #225.

o Documentation from the following completed investigations:

Case #	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
Sample D.1					
38506489	Physical Abuse (2)	Unconfirmed (2)	12/31/10 3:39 pm	1/2/11 2:05 pm*	1/9/11
38506776	Emotional Abuse	Unfounded	12/31/10 10:54 pm	1/2/11 12:42 pm*	1/9/11
3850338	Physical Abuse	Unconfirmed	12/31/10 3:45 am	12/31/10 12:55 pm	1/7/11
38513362	Physical Abuse (3)	Unfounded (3)	1/5/11 3:13 pm	1/6/1 2:30 pm	1/12/11
38515710	Physical Abuse (2)	Confirmed (2)	1/6/11 3:39 pm	1/7/11 4:05 pm*	2/5/11 2 extensions
383520582	Physical Abuse (2) Neglect (1)	Inconclusive (2) Unfounded	1/7/11 8:03 pm	1/8/11 11:45 am	2/6/11 2 extensions
38521472	Physical Abuse (2)	Unconfirmed (2)	1/9/11 12:23 am	1/10/11 2:14 pm*	1/27/11 extension
38565778	Emotional Verbal Abuse	Unconfirmed	1/21/11 4:42 pm	1/23/11 1:35 pm*	1/31/11
38552232	Physical Abuse (2)	Unconfirmed (2)	1/18/11 3:32 pm	1/19/11 10:18 am	1/28/11
38675231	Physical Abuse	Unconfirmed	2/25/11 8:16 am	2/25/11 11:10 am	3/6/11
38553004	Sexual Abuse (6)	Unfounded (6)	1/18/11 9:26 pm	1/19/11 3:00 pm	1/27/11
38553066	Neglect (4)	Unconfirmed (4)	1/18/11 10:54 pm	1/20/11 10:45 am*	1/27/11
38561670	Neglect	Confirmed	1/20/11 11:24 pm	1/21/11 1:30 pm*	2/8/10 extension
38572010	Emotional Verbal Abuse (1) Physical Abuse(1)	Unconfirmed Unconfirmed	1/24/11 4:24 pm	1/26/11 3:35 pm*	2/2/11
38593611	Neglect (2)	Unfounded (1)	1/31/11	2/1/11	2/3/11

		Unconfirmed (1)	8:56 am	7:20 am	
38597328	Physical Abuse (3)	Unconfirmed (3)	1/31/11 5:20 pm	2/1/11 9:55 am	2/10/11
38625153	Physical Abuse (2)	Unconfirmed (2)	2/10/11 9:17 am	2/10/11 2:30 pm	2/15/11
38520585	Serious Injury Neglect	Unconfirmed	1/7/11 8:03 pm	1/8/11 11:45 am	1/17/11
37426460	Neglect (3) Physical Abuse (7)	Unconfirmed (3) Confirmed (2) Unconfirmed (5)	8/13/10 6:35 am	8/13/10 7:55 am	10/18/10 6 extensions
37749061	Sexual Abuse (12) Physical Abuse(5)	Unfounded (12) Unfounded (5)	9/2/10 9:46 am	9/2/10 3:30 pm	9/10/10
38157921	Physical Abuse (2)	Unconfirmed Other	9/28/10 10:02 pm	9/30/10 4:00 pm*	10/7/10
38276946	Exploitation	Unconfirmed	10/9/10 5:44 pm	10/12/10 4:39 am*	10/26/10 extension
38464370	Physical Abuse Neglect (5)	Confirmed Confirmed (5)	12/1/10 1:15 pm	12/2/10 11:00 am	12/9/10
38468736	Physical Abuse	Confirmed/Reportable Conduct	12/5/10 8:18 am	12/5/10 2:10 pm	12/21/10 extension
38481568	Emotional/Verbal Abuse Neglect (2) Physical Abuse	Unfounded Unfounded Unfounded	12/15/10 7:05 pm	12/17/10 1:20 pm*	12/23/10
38501350	Physical Abuse	Unconfirmed	12/28/10 6:14 pm	12/30/10 3:30 pm*	1/5/11
38497747	Sexual Abuse	Unfounded	12/26/10 1:19 pm	12/26/10 2:00 pm	12/31/10
38503314	Physical Abuse	Unfounded	12/29/10 8:02 pm	12/31/10 2:02 pm*	1/4/11
38503325	Sexual Abuse (2)	Unfounded (2)	12/29/10 8:41 pm	12/30/10 11:20 am	1/4/11
Sample D.2	Type of Incident	DFPS Disposition	Time of Incident	Began Investigation	Closed Investigation
110121	Serious Injury Neglect	Inconclusive	8/20/10 11:00 am	8/23/10 7:55 pm	8/24/10
110122	Neglect	Administrative Referral	1/22/11 4:57 pm	Unknown	1/24/11
110207	Neglect	Administrative	2/2/11	Unknown	Not dated

		Referral	10:46 am		
110124	Neglect	Administrative Referral	1/24/11 10:04 am	Unknown	1/24/11
110113	Physical Abuse	Administrative Referral	1/14/11 1:50 pm	Unknown	1/18/11
110115	Serious Injury Neglect	Administrative Referral	1/15/11 7:50	Unknown	Not dated
110217	Client Supervision	I & R	2/17/11 9:03 am	2/17/11 11:55 am	2/17/11
110107	Serious Injury Determined Cause	n/a	1/6/11 11:00 pm	Unknown	Not dated
110107	Serious Injury Aggression to Peer Offender	n/a	1/7/11 2:13 pm	Unknown	1/10/11
110119	Serious Injury Determined Cause	n/a	11/18/11 4:15 pm	Unknown	Not dated
110118	Serious Injury Determined Cause	n/a	1/18/11 11:44 am	Unknown	Not dated
110131	Serious Injury Aggression to Peer Offender	n/a	1/31/11 Unknown	Unknown	2/1/11
Sample D.3					
110213	Death	n/a	2/13/11 3:15 pm	Unknown	2/13/11
10210	Arrest	n/a	2/10/11 8:26 pm	Unknown	2/10/11
110312	Serious Injury Aggression to Peer Offender	Unknown	3/12/11 10:19 am	Unknown	3/14/11
110112	Arrest	n/a	1/11/11 4:50 pm	Unknown	1/12/11
110118	Jail	n/a	1/18/11 2:00 pm	Unknown	Not dated

* = late

	Interviews and Meetings Held: o Informal interviews with various individuals, 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 Charles Bratcher, Quality Services Director o Justin Vest, Risk Officer o Pat Samuels, Incident Management Coordinator o James Watson, Facility Investigator Observations Conducted: o Observations at residences and day programs o Daily Incident Management Review Team Meeting 3/14/11 and 3/15/11 o Behavioral Therapy Committee Meeting 3/14/11 o Restraint Reduction Committee Meeting 3/16/11 o Human Rights Committee Meeting 3/15/11 o Shamrock Unit Meeting 3/15/11 o Quarterly PST meeting for Individual #225 o Annual PSP meetings for Individual #374 and Individual #413
	Facility Self-Assessment: The facility POI indicated that MSSLC had taken steps towards compliance in areas cited during the last monitoring visit. The facility had implemented a process for auditing significant injuries as required in D2i. This system implemented appeared to be sufficient to meet this requirement. The facility had also implemented new procedures to address delinquent training in abuse and neglect. While this appeared to have impacted the number of staff in compliance with training requirements, the facility was still not in compliance with this item. The facility POI indicated that deficiencies noted during the last monitoring review in terms of recommendations and follow-up to incidents were now being addressed by the facility. The monitoring team found this an area where little progress had been made towards compliance. The facility POI indicated that MSSLC was in compliance with the mandate to trend incidents and develop a plan to address any trends noted, the monitoring team did not find this process adequate to meet the requirements of this provision.
	Summary of Monitor's Assessment: The facility had not yet compiled data in a trend report for abuse and neglect incidents occurring during the quarter prior to the monitoring visit. The latest trend report provided to the monitoring team was for FY10 4th quarter (6/1/10-8/31/10). According to a summary of abuse, neglect, and exploitation trends for FY10 4th quarter provided to the monitoring team, investigation of 562 cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 6/1/10 through 8/31/10. Of these 562 cases, 14 (2%) were

	confirmed by DFPS. Although not trended, a log of all DFPS cases from FY11 1st quarter (9/1/10-12/31/10) listed a total of 564 cases reported. There had been a significant increase in the number of abuse and neglect allegations from FY10 3rd (345) quarter to FY10 4th quarter (562). The facility trend report attributed the increase to an increase in the number of false allegations made by individuals at MSSLC. The number of cases remained fairly constant from FY10 4th quarter to FY11 1st quarter with an increase of less than 1%. Thirty-eight allegations had been confirmed by DFPS in the 564 cases reported during FY11 1st quarter (7%). Some of the cases included multiple allegations. Of the confirmed allegations, there were 16 confirmed incidents of physical abuse, 20 confirmed incidents of neglect, one confirmed exploitation allegation, and one confirmed allegation of emotional/verbal abuse. There were a total of 847 injuries reported during FY10 4th quarter. Trends were not yet available for injuries reported during FY11 1st quarter. A log of serious injuries at the facility listed a total of 15 serious injuries reported at the facility for FY11 1st quarter. This was a significant decrease from the 29 serious injuries recorded from FY10 4th quarter. Twelve of the 44 serious injuries were attributed to aggression by peers, 15 resulted in fractures, and 19 required sutures or dermabond. MSSLC was fortunate to have a team of seasoned investigators that had developed a good system for dealing with the massive numbers of incidents and investigations at the facility. It was noted that behavioral issues were the underlying cause for a majority of the incidents and injuries that occurred at the facility. In order to reduce the number of incidents and injuries significantly, the facility will need to develop a comprehensive plan to restructure programming in a way that will have a greater impact on reducing behavioral incidents at the facility. It is of great concern to the monitoring team that individuals at the facility continue to be at risk for harm in their current environment at MSSLC.

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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.	The facility's policies and procedures: • Included a commitment that abuse and neglect of individuals will not be tolerated, and • Required that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. In practice, the facility's commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect was illustrated by the following examples: • There were posters regarding this mandate posted throughout the facility.	Substantial compliance

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		• In informal interviews throughout the facility, it was clear that staff had been trained on reporting abuse and neglect. When the monitoring team questioned staff regarding what action they would take if they witnessed or suspected abuse or neglect, all staff consistently stated that they would report the incident to DFPS and to the facility director. • Competency-based training on abuse and neglect (ABU0100) was required annually for all employees. Training transcripts for 24 current employees at the facility were reviewed for current ABU0100 training. Of these, 24 (100%) had completed the course ABU0100 in the past 12 months. • All employees involved in confirmed cases of abuse in the sample reviewed by the monitoring team were dismissed following completion of investigations by DFPS. In practice, the facility adhered to the policy for zero tolerance for all employees at MSSLC. The facility was rated as being in compliance with this provision item.	
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 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	According to MSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy IV.B.1, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS and then their immediate supervisor. This was consistent with the requirements of the Settlement Agreement. With regard to serious incidents, the facility policy entitled Incident Management required that all serious incidents be reported to the facility director to be reported to DFPS within one hour if abuse or neglect was suspected, to DADS regulatory within 24 hours, and to DADS state office the next working day, if required. This policy was consistent with the requirements of the Settlement Agreement. According to data provided by the facility from 1/1/10 – 2/28/11, the following allegations were investigation by DFPS: • Total abuse allegations – 2040 o Confirmed – 111 (5%)	Noncompliance

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	official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	o Unconfirmed – 748 (37%) o Unfounded – 810 (40%) o Inconclusive – 62 (3%) o Administrative Referral – 305 (15%) o Other – 3 (<1%) • Total neglect allegations - 337, including: o Confirmed – 57 (17%) o Unconfirmed – 247 (73%) o Inconclusive – 27 (8%) • Total exploitation allegations - 22, including: o Confirmed – 2 (1%) o Unconfirmed – 8 (37%) o Inconclusive – 4 (18%) o Administrative Referral – 8 (36%) • Other serious incidents investigated by the facility included: o Unauthorized Departures – 3 o Sexual Incidents – 2 o Deaths – 1 o Serious Injuries Determined Cause – 28 o Serious Injuries Undetermined Cause – 4 Based on an interview of eight staff responsible for the provision of supports to individuals, eight (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation and other serious incidents. Two samples of investigations were selected for review. These included: • Sample #D.1 which included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample. • Sample #D.2 which included a sample of facility investigations. Some of these were investigations that had been referred to the facility by DFPS, while others were investigations the facility completed related to serious incidents. See the list of documents reviewed for investigations included in this sample. In addition to the investigation reports contained in Sample #D.1 and Sample #D.2, additional incident reports were selected for review. Sample #D.3 was the sample of those additional serious incidents investigated by the facility. Based on a review of the 30 investigation reports included in Sample #D.1:	

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		• Twenty-nine (96%) of 30 reports in the sample indicated that DFPS was notified within one hour. o In DFPS case #38520582, the UIR indicated that the individual's progress notes documented and allegation of abuse at 6:30 pm on 1/7/11. Campus Coordinator log documented the allegation of abuse at 6:46 pm. It was not reported to DFPS until 8:03 pm. • Thirty (100%) indicated, the facility director or designee was notified within one hour. • Twenty-eight (100%) indicated OIG or local law enforcement (when appropriate) was notified within the timeframes required by the facility policy. • Thirty (100%) investigation reports in the sample indicated when or if DADS regulatory or the state office was notified by the facility. Based on a review of 10 incident reports included in Sample #D.2: • Five (50%) showed evidence that serious incidents were reported within the timeframes required by the state policy. The exceptions were: o For UIR #110115, a serious injury of unknown cause was confirmed by the physician at 7:50 pm on 1/15/11. It was not reported to DFPS until 1/16/11 at 2:12 pm. The state office was not notified until 12:08 on 1/18/11. o UIR #110124 was not reported to the state office until 12:15 pm the following day. o UIR #110113 involved a serious injury of unknown cause discovered on 1/6/11. It was not reported to DFPS until 1/14/11. o UIR #110119 involving a serious injury was not reported to the State Office until 12:30 pm the following day. o UIR #110118 was a serious injury that occurred on 1/18/11 at 11:44 am. It was not reported to the State Office until 12:30 pm on 1/20/11. The facility had a standardized reporting format. The facility used the Unusual Incident Report Form designated by DADS for reporting all unusual incidents. This form was adequate for recording information on the incident, follow-up, and review. Based on a review of 16 incident reports included in Sample #D.2 and Sample #D.3: • Sixteen (100%) utilized the standardized reporting format. The facility was not in compliance with this item due to need to report serious incidents in the required timeframe. The facility needs to ensure notification is made to all parties required within required timeframes and document this information on the UIR.	

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	(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.	According to MSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy the facility was mandated to assure the safety and protection of individuals by immediately removing alleged perpetrators. Procedures for removing the alleged perpetrator were described in the policy in section IV.B.9. Based on a review of 20 investigation reports with known alleged perpetrators (AP) included in Sample #D.1, 20 (100%) of alleged perpetrators were removed from direct contact with individuals immediately following the facility being informed of the allegation when the AP was known. Based on a review of 20 investigation files in which the AP was identified and the facility Abuse and Neglect Employee Reassignment Log, 17 (85%) indicated that staff that had been removed from direct contact were reinstated only after a well-supported preliminary assessment showed that the employee posed no risk to individuals or the integrity of the investigation or the conclusion of the investigation allowed their return to direct contact duties, or the employee was not returned to the position due to the outcome of the case. The following cases are examples that showed documentation that the facility was in compliance with this provision: • In DFPS cases #38468736 and #38464370, the investigation file included documentation of the AP's dismissal following DFPS's determination of confirmed abuse or neglect allegations. • In DFPS cases #38157921, #38276946, #38276946, #38625153, 337749061, #38157921, #38481568, #38501350, #38497747, #38503325, #38503314, #38505338, #38506489, #38513362, and #38521472, the investigation file included evidence that the AP was not allowed to return to a position requiring contact with individuals until the case was completed and allegations were unconfirmed. The following is an example that did not document compliance with this provision: • The investigation file for DFPS#38515710 and the facility reassignment log did not include information regarding disciplinary action taken by the facility following the completed investigation with confirmation of abuse. • The investigation file for DFPS #38561670 indicated that the AP was removed from direct contact with individuals immediately. The UIR included recommendations for disciplinary action and retraining, but the file did not contain evidence that either had been completed to address the confirmed neglect allegation prior to the employee being reinstated.	Noncompliance

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		• The investigation file for DFPS #38552232 indicated that the AP was removed from direct contact with individuals immediately. The UIR included a recommendation for retraining on PMAB to address concerns noted in the DFPS report. The file did not contain evidence that the retraining had occurred prior to the AP's return to his position. The facility did have a system in place for assuring that alleged perpetrators were not returned to regular duty until notification was made by the facility investigator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of the case. A review of the 10 UIRs in sample D.2 was completed to determine if adequate action was taken to protect individuals involved in serious incidents. All (100%) indicated that some type of immediate action was taken to protect the individual following the incident. • As noted in C.1, two serious injuries of unknown cause were not immediately reported to DFPS for investigation. • In all cases involving alleged perpetrators, it was documented that the AP was immediately removed from contact with individuals. • In all cases where appropriate, a medical assessment was completed immediately to assess for further injury. Client Injury Reports for Individual #514 indicated that six of her documented 17 injuries were caused by aggressive acts from other individuals. • On 11/24/10, an altercation at home resulted in bruises to her temple and neck, a busted lip, and a nose bleed. • On 12/15/10, she was pushed down at day camp by a peer resulting in an abrasion to her elbow. • On 1/16/11, a peer bit her on the back during an altercation at home. • On 1/24/11, she was attacked by a peer at home causing injuries to her eye, bruising to the back of her head, and redness to her back. • On 1/26/11, she was in an altercation at the workshop and obtained a bruise to her thigh and a scratch to her finger. • On 1/30/11, she was attacked by a peer while in the community resulting in bruising to her face. She had a BSP in place and was on one-to-one supervision. There was no indication that her PST had met to discuss strategies to reduce the incidents of aggression by peers towards this individual or to discuss the number of injuries for the past quarter. CIRs indicated that 17 of the 18 injuries documented for Individual #492 were due to self	

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		injurious behaviors (SIB). He had a BSP in place and was on one-to-one supervision. The PST had met 12 times since 1/5/10. Most of the meetings were just to review whether or not his current level of supervision was appropriate. There was no discussion regarding the fact that his current BSP and supervision level were not effective in reducing the number of SIB incidents and injuries. The one injury not attributed to SIB was an injury to his head that occurred due to an accident. The safety office reviewed the incident. The facility needs to address any concerns that may have contributed to the incident with recommendations for correction when appropriate. Investigation files should include documentation of any follow-up action taken, including disciplinary action, in the facility report. Given the large number of investigations that the incident management team must complete, it might be more efficient to assign developing and tracking recommendations for completed investigations to the quality assurance department. All injuries that may be a result of abuse or neglect should be reported to DFPS within one hour. The facility was not in compliance with this 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 state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. It further mandated that all supervisors must ensure that required training is appropriately documented by certification and date of completion as directed by the Health and Human Services Commission's Facility Support Services' Competency Training and Development Department. Documentation of training was kept by the facility and a sample of 24 staff training transcripts was reviewed. Not all training had been completed as required, though there had been an increase in the percentage of adequately trained staff since the last monitoring visit. A review of the training curricula related to abuse and neglect and incident management was reviewed for: (a) new employee orientation and (b) annual refresher training. The results of this review were as follows: Review of 24 staff records (Sample #C.2), showed that; • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 18 (88%) of 24 employees with current training completed this training within 12 months of the date of previous training. • 20 (84%) of the 24 employees had completed competency based training on	Noncompliance

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		unusual incidents (UNU0100) refresher training within the past 12 months. • 10 (42%) of the 18 employees with current training completed this training within 12 months of the date of previous training. The facility POI indicated that new requirements at the facility include the practice of removing staff members from direct contact with individuals if deadlines for training or retraining in abuse and neglect were not met. Based on interviews with 10 staff: • Ten (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The facility needs to ensure that all employees receive annual training as required by the 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.	According to MSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy item IV.A.5, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation during pre-service and every 12 months thereafter. A sample of this form was requested for 24 current employees at the facility and all staff hired within the past two months. • Twenty-four of 24 (100%) had signed a form acknowledging their obligation to report within the past 12 months. • Seventy-six of 76 (100%) new staff hired in the past two months had signed a form acknowledging their obligation to report. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility was in substantial compliance with this item.	Substantial Compliance
	(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	MSSLC policy on abuse and neglect did not address this mandate. A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. The guide was a	Noncompliance

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	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.	clear easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. In interviewing a sample of eight individuals, all eight (100%) were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. Based on a review of 10 individuals' PSPs (Sample #D.4), six (60%) indicated the individual, or their LAR and/or other significantly involved individual, had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. The facility was in compliance with this provision at the last monitoring review. The four PSPs where this information was not found were new style format PSPs, including the PSPs for Individual #132, Individual #228, Individual #548, and Individual #497. QMRPs will need to be reminded to include this information in the new PSP plan development process. The facility was not in compliance with this provision. Documentation that information on identifying and reporting unusual incidents was shared with the individual and/or their LAR will need to be maintained by the facility.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	MSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy section did not address this mandate. A review was completed of the posting the facility used. It included a brief and easily understood statement of: • individuals' rights, • information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that all but one of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. An assistant ombudsman position had been created at the facility. There was also a rights officer position. Information was posted around campus identifying the rights officer. The facility was attempting to develop a more active self-advocacy group on campus. Monitoring team members had the opportunity to attend a self-advocacy group meeting	Substantial Compliance

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		during the visit. The meeting was about MSSLC vocational training. It did not focus on any self-advocacy activities (also see section E1). The facility was rated as being in substantial compliance with this provision item.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to MSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy item IV.A, The policy stated that the reporting of abuse/neglect to the Office of the Inspector General involving possible allegations of criminal activity will be done by DFPS. Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented. OIG provided the facility with an email notifying the facility of the conclusion to their investigation. Based on a review of 30 allegation investigations completed by DFPS (Sample #D.1), in 28 for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 28 (100%). OIG investigated 18 of the 28 cases (64%) referred in the sample. The facility investigator reported that the facility had a cooperative working relationship with both OIG and local law enforcement. The facility is in substantial compliance with this 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.	According to MSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy Item IV.A.13, the facility prohibited any retaliatory action towards person(s) reporting suspected abuse, neglect, or exploitation. The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • MSSLC policy addressed this mandate. • Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this it occurred. Based on a review of investigation records (Sample #D.1), there were no concerns noted related to potential retaliation. The facility was in substantial compliance with this item.	Substantial compliance

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	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The facility Incident Management Policy did not require an audit that evaluated whether significant resident injuries were reported for investigation at least semi-annually. Sample #D.2 included investigations completed on a sample of injuries. As noted throughout section D, these investigations appeared to be routine for significant injuries. Additionally, a sample of injury reports and supporting documentation was reviewed for injuries since 11/1/10 for Individual #514, Individual #492, Individual #508, and Individual #225. The sample included a total of 60 injuries, of those, 45 were witnessed and five were discovered injuries. The Client Injury Report (CIR) for Individual #492 dated 12/2/10 indicated that the injury was witnessed, though staff stated that she discovered the injury. The five discovered injuries were all minor scratches and bruises. None were investigated. CIRs indicated that 17 of the 18 injuries documented for Individual #492 were due to self injurious behaviors (SIB). The one injury not attributed to SIB was an injury to his head that occurred due to an accident. The safety office reviewed the incident. A sample of Daily Unit Meeting minutes for 11/1/10-1/31/11 were reviewed and indicated that injuries of both known and unknown cause were reviewed the next working day following the injury or discovery of the injury. Observation of both the Daily Unit Meeting and Daily Incident Review Team meeting during the monitoring visit confirmed that injuries were reviewed by both teams and follow-up recommendations were made when warranted. Justin Vest, Risk Officer reported that the facility conducted a random audit of serious injuries and non-serious injury trends for contributing factors. This was confirmed by documentation on the CIRs in the review. The facility was in substantial compliance with this provision item.	Substantial compliance
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		

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	involving Facility residents. Such policies and procedures shall:		
	(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.	The MSSLC Incident Management Policy • described a comprehensive manner of the conduct of all such investigations; • did not address training requirements for investigators; and • did not require that investigators be outside of the direct line of supervision of the alleged perpetrator. The monitoring team did not review curricula used by DFPS in training its investigators and cannot comment on its content and whether or not it is competency based. Because DFPS case investigations reviewed by the monitoring team were generally thorough and comprehensive, and because case reports were generally well written, the monitoring team believes that the training DFPS investigators receive was achieving the desired results. DFPS reported its investigators were to have completed APS Facility BSD 1 & 2, or MH & MR Investigations ILSD and ILASD, depending on their date of hire. While not required, it appears most investigators also took a class titled "MH&MR Overview – APS Investigator Role." Completion of this class would demonstrate training in working with people with developmental disabilities. Eleven DFPS investigators were assigned to complete investigations at MSSLC. The training records for DFPS investigators were reviewed with the following results: • Eleven out of 11 DFPS investigators (100%) had completed the requirements for investigations training. • Eleven out of 11 DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. MSSLC had five designated facility investigators. The training records for facility investigators were reviewed with the following results: • Five out of five facility investigators (100%) had completed CIT0100 Comprehensive Investigator Training; • Five (100%) had completed UNU011 Unusual Incidents within the past 12 months; • Five (100%) had completed Root Cause Analysis according to training transcripts reviewed. One facility investigator reported that he had recently completed training in RCA. He facilitated RCA at a PST meeting during the monitoring visit. o The facility should include documentation of Root Cause Analysis training on the training transcript for each investigator.	Noncompliance

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		• Five out of five facility investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. None of the staff designated as investigators had supervisory responsibilities and, therefore, were not in the direct line of supervision of anyone subject to investigation. The facility was not in compliance with this provision. The facility needs to update incident management policies.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Based on MSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy Item IV, staff were required to cooperate with DFPS and OIG during investigations. Review of the investigation files in Sample #D.1 showed that in 30 out of 30 investigations (100%), facility staff cooperated with DFPS investigators. Although OIG did not provide a detailed report to the facility, there was no indication that staff had not cooperated with OIG in investigations. Pat Samuels, Incident Management Coordinator reported that the facility had a cooperative relationship with both DFPS and OIG. Interagency meetings with MSSLC, OIG, and DFPS are now being held quarterly. The facility is in substantial compliance with this item.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS, the following was found: • Of the 30 the investigation records from DFPS (Sample #D.1), 28 had been referred to law enforcement agencies. OIG completed investigations in 18 of the cases referred. For 18 out of these 18 (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. This was documented through correspondence between OIG, local law	Substantial Compliance

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		enforcement, DFPS, and MSSLC The facility was found to be in substantial compliance with this provision.	
	(d) Provide for the safeguarding of evidence.	According to MSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, staff were mandated to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Exhibit B of the policy provided guidelines for the securing of evidence. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • There was no indication that evidence was not safeguarded during any of the investigations. Video monitoring footage was provided to DFPS as requested. Photographs were taken of injuries and shared with investigators as necessary. The facility was in substantial compliance with this 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 facility Incident Management policy mandated that investigations of serious incidents: • were to commence within one hour (Item IV.B.3.1); • were to be completed within five calendar days of the incident (Item VI.D.3); • did not require a written extension request from the facility director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances (the policy, however, needed to be revised to require these written extensions); and • were to document results in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action (Item VI.C). To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Seventeen out of 30 (56%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well	Noncompliance

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		as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. o Please note: DFPS and the monitoring teams have discussed this issue and DFPS indicated that it planned to make the commencement of the investigation more explicit in the investigation report. In this way, actions taken by DFPS to commence an investigation will be clearly indicated. • Twenty-two out of 30 (73%) were completed within 10 calendar days of the incident. o For all investigations not completed within 10 days there was documentation of a written extension request that had been approved by the Adult Protective Services Supervisor. o Three cases had 2 or more extensions requested. OIG was involved in investigating these three cases, so some of the delay was attributed to delays while OIG finished their interviews of witnesses. o One (<1%) of the eight investigations that were not completed within 10 days was completed in 30 or more days. • All 30 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In 10 (33%) of the 30 investigations reviewed, concerns or recommendations for corrective action were included. The following are examples of investigations that included appropriate recommendations: o For DFPS #38552232, the investigator noted that there was a concern that an employee restrained the individual in an unapproved hold. She recommended retraining in PMAB for the employee. o For DFPS #38561670, the investigator expressed concern that direct support staff were playing pool and did not notice on of the individuals leave the home. o For DFPS #38675231, the investigator expressed concern that direct support staff did not document the incident or the restraint leading to the investigation. o In DFPS #38515710, the investigator raised concern that documentation of the restraint that occurred during this incident did not resemble the restraint seen on video footage. o In DFPS case #38506489, the investigator recommended that employees involved in the incident go through PMAB refresher training. o In DFPS case #38468736, the investigator expressed concern that the individual was not following her PT plan during mealtime.	

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		Facility Investigations The following summarizes the results of the review of facility investigations from sample #D.2 and #D.3: • One out of 16 (6%) of the UIRs reviewed indicated when the investigation commenced. Fifteen of the UIRs did not include the date or time of actions taken by the investigator. UIR #110217 documented that the investigator "communicated with the CC regarding the AP. The AP has been indentified and removed from client contact" at 11:55 on 2/17/11. This was within 24 hours of the allegation. o The monitoring team was unable to determine compliance with timely completion of investigations because UIRs in the sample did not clearly document when investigations were completed by the facility. ▪ Six of the 17 (35%) reports were not dated by the investigator. These included UIR #110118, #110207, #110115, #110107, #110119, and #110118. ▪ Although all investigations appeared to be completed within 10 days of the incident, investigations in the sample that were dated by the investigator did not appear to be dated with the date that the investigation concluded. For example, UIR #110122 indicated that the facility investigator completed the investigation on 1/24/11, but DFPS did not refer the case back to the facility until 1/26/11. UIR #110124 indicated that the facility investigator completed the report on 1/24/11, but DFPS did not refer the investigation back to the facility until 1/27/11. • Twelve of the 15 (80%) of the investigations completed in the sample indicated that the facility director had reviewed the report upon completion. The exceptions were UIR #110213, UIR #110124, and UIR#110217. One case was completed the week of the monitoring visit and had not yet been reviewed. • All 16 (100%) investigations resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In 16 of the investigations reviewed, recommendations for corrective action were included in four of the investigations (25%). Examples where recommendations were made by the investigator included: o UIR #110213 involving a death, included 11 recommendations to address staff performance and systemic issues identified during the investigation	

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		o UIR #110207 included recommendations regarding disciplinary action for staff involved in the incident and retraining of staff on the individual's PNMP. • Examples of documentation that did not support that appropriate recommendations were made included: o UIR #110112 and UIR #110118, both involving an arrest of an individual for assault, did not address recommendations for behavioral intervention or staff training to avoid reoccurrence of a similar incident. Neither investigation included recommendations or action that needed to be taken to follow up with the arrest. The recommendation section of the reports noted "none at this time." o UIR #110115 involved a serious injury of unknown cause. There were no recommendations made in the case to follow up on the injury or to retrain staff on follow-up to documentation and reporting, although the investigation noted that staff documented the individual's distress a day before medical treatment was provided in a late entry. There were also no recommendations to review the PNMP for appropriateness following the injury or to retrain staff on transferring the individual to reduce the likelihood of additional injuries. o UIR #110113 was an investigation due to a serious injury of unknown cause. The UIR did not include recommendations for medical or PNM follow-up to the injury. o UIR #110107 was an investigation due to a serious injury resulting from the individual punching a window. The UIR did not include recommendations for follow-up medical care, supervision, or review of behavioral interventions. The investigator noted "NA" in the recommendation section of the report. The facility needs to ensure that documentation reflects the time and date of investigation activities, the date that the investigation concluded, and develop recommendations to address any follow-up action that needs to be taken by the facility. The facility investigator and director should sign the report upon review. The facility was not in compliance with this provision.	
	(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	Based on a review of MSSLC Incident Management Policy Item VI.B, it required that a UIR be completed for each serious incident. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below; the findings related	Noncompliance

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	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.	to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations for sample #D.1: • In 30 out of 30 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately, the following: o In 30 (100%), each serious incident or allegations of wrongdoing; o In 30 (100%), the name(s) of all witnesses; o In 30 (100%), the name(s) of all alleged victims and perpetrators(when known); o In 30 (100%), the names of all persons interviewed during the investigation; o In 30 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 30 (100%), all documents reviewed during the investigation; o In 0 (0%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In 30 (100%), the investigator's findings; and o In 30 (100%), the investigator's reasons for his/her conclusions. Sample #D.2 included investigations that were referred back to the facility for review because they did not meet DFPS definitions for abuse or neglect. • It is a concern that UIR #110115 was referred back to the facility for investigation because DFPS "does not investigate injuries of unknown cause." Without at least a preliminary investigation, it was not possible for DFPS to rule out neglect. It was likely that the individual's serious injury could have occurred during routine care. DFPS did not look at whether or not treatment plans were being followed as written or if staffing was sufficient to carry out treatment plans. According to Chapter 711.19 of the Texas Administrative Code, neglect is defined as a negligent act or omission by any individual responsible for providing services to a person served, which caused or may have caused physical or emotional injury or death to a person served or which placed a person served at risk of physical or emotional injury or death. Neglect includes, but is not limited to, the failure to: (1) establish or carry out an appropriate individual program plan or treatment plan for a person served, if such failure	

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		results in a specific incident or allegation involving a person served (2) provide adequate nutrition, clothing, or health care to a specific person served, including the failure to maintain adequate numbers of appropriately trained staff, if such failure results in a specific incident or allegation involving a person served. According to DADS, DFPS was preparing to implement policy and procedure that will instruct investigators to document the results of the prior case history review in the investigative report whether it was used or not. Currently, this information was stored in the IMPACT case management system, but did not transfer to the written report. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • In 15 out of 16 investigations reviewed (94%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. o For a serious injury involving Individual #266 documented on UIR #110115, the investigation report indicated that a late entry was made on 1/14/11 indicating that support staff noticed the individual discomfort at 4:00 pm. The investigator did not note whether or not this was followed up on. The witness statements addressed the events of 1/15/11, though it appeared that the fracture may have occurred prior to that date. The investigator did not look at the individual's PT plan or transfer/repositioning logs, though it was likely that the injury could have occurred during transfer or repositioning. o DADS has indicated that DFPS does not investigate injuries of unknown origin when a medical professional indicates that the injury is not suspected to be the result of abuse or neglect. If abuse or neglect is not suspected, the intake information and any information gathered by the investigator are referred back to the facility for further action. • The report utilized a standardized format that set forth explicitly and separately, the following: o In 16 (100%), each serious incident or allegations of wrongdoing; o In 16 (100%), the name(s) of all witnesses; o In 16 (100%), the name(s) of all alleged victims and perpetrators when known; o In 16 (100%), the names of all persons interviewed during the investigation; o In 14 (88%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made UIR	

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		#110207 and #110113 did not include interview summaries completed by the facility. Only one UIR (6%) included the time and date of interviews conducted during the investigation. o In 16 (100%), all documents reviewed during the investigation; o In 16 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. o In 15 (94%), the investigator's findings (the exception was UIR #110113); and o In 15 (94%), the investigator's reasons for his/her conclusions (the exception was UIR #110113. DFPS investigations did not include the allegation history relevant to the current case for the victim or perpetrator. The facility investigations need to include the time and date of interviews. The facility is not in compliance with this provision.	
	(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.	Based on review of MSSLC Incident Management Policy at section VII.C, the policy required that the facility investigator must complete the Final Facility Investigation Report using the UIR format for each incident. This report is to be reviewed and approved by the facility incident management team within five working days of the initial report of the incident or upon completion by DFPS. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of a sample of 29 DFPS investigations included in Sample #D.1: • In 23 out of 29 investigation files reviewed (79%), there was evidence that the DFPS investigator's supervisor had conducted a review of the investigation report. Files that did not include approval by the supervisor were DFPS case #38520585, #38497747, #37426460, #38157921, #38276946, and #37749061. • UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC), Director of Facility, and Independent Ombudsman. Five DFPS investigations were reviewed for facility review and approval including DFPS case #38565778, #38553004, #38553066, #38593611, and #38597328. o All were reviewed by the IMC within one day of completion.	Noncompliance

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		o Four of five (80%) were reviewed by the Facility Director within five days of completion. Case #38593611 was reviewed by the facility director six days after completion. Facility Investigations In 10 out of 11 (90%) UIRs from sample #D.2 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon completion. • UIR #110113 was not signed by the facility director. • Four UIRs (36%) indicated review on the day that the investigation was completed by a typewritten name and date. None of the four reports included the facility director, Incident Management Coordinator, or lead investigator's signature. This included UIR #110107, #110119, #110118, and #110131. • Five UIRs were not dated by the facility investigator indicating the date completed. There was no indication that review resulted in identification of any deficiencies in any of the final reports. The facility needs to ensure all investigations are promptly 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 should be noted and addressed by the reviewer. The facility was not in compliance with this provision.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A UIR was completed for each unusual incident in the sample.	Substantial Compliance
	(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.	According to MSSLC Incident Management Policy IV, the Department Director is responsible for implementing the recommendations and assignments and any additional actions necessary to prevent recurrence of the incident and forward actions taken to the Incident Management Coordinator within timelines assigned by the Facility Incident Management Team. In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included in Sample #D.1 and Sample #D.2 was selected for review. This subsample, Sample #D.4, included the following investigations: UIR#110207, DFPS #38561670, DFPS #38552232, DFPS #38315710, DFPS #37426460, DFPS #38520585, and DFPS #38468736.	Noncompliance

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		Documentation was requested to show what follow-up had been completed to address the recommendations resulting from these investigations. The following summarizes the results of this review: • For two out of six of the investigations reviewed (33%), prompt and adequate disciplinary action had been taken and documented. For example, the following disciplinary actions had been taken: o For UIR #110207, an AP was terminated following the facility's investigation of an incident involving alleged neglect. o For DFPS #38468736, documentation was provided that indicated the AP was terminated following the conclusion of the investigation. An allegation of physical abuse was confirmed. • The following are examples of investigations for which prompt and appropriate disciplinary action was not documented: o The investigation file for DFPS #38561670 indicated that the AP was removed from direct contact with individuals immediately. The UIR included recommendations for disciplinary action and retraining, but the file did not contain evidence that either had been completed to address the confirmed neglect allegation prior to the employee being reinstated. o For DFPS case #37426460, the investigation file did not contain documentation of the disciplinary action taken as a result of the confirmed allegation of physical abuse. A note on the OIG summary indicated that the AP was terminated. o The investigation file for DFPS #38552232 indicated that the AP was removed from direct contact with individuals immediately. The UIR included a recommendation for retraining on PMAB to address concerns noted in the DFPS report. The file did not contain evidence that the retraining had occurred. o For DFPS #38315710, an allegation of physical abuse was confirmed. The facility investigation file did not include documentation of disciplinary action taken in the case. The employee reassignment log indicated that the APs were removed from individual contact immediately but did not indicate if they were terminated following the outcomes of the case. • As noted in D.3.e, recommendations for appropriate programmatic follow-up to address the incident was not found in all reports reviewed. Specific examples are given in D.3.e of action that should have been taken following the	

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		investigation. Additional examples found where recommendations were made for programmatic action, but follow-up was not documented in the investigation file include: o In DFPS case #38315710, the DFPS investigator expressed concern regarding appropriate supervision for individuals viewed in the surveillance video and the restraint that was implemented during this incident. The facility investigator included recommendations to address these concerns in the facility UIR. Evidence that action was taken on these recommendations was not included in the investigation file. o In DFPS case #37426460, the DFPS investigator expressed several concerns regarding staff testimony and actions during the incident. The facility recommendations simply stated "Barnett unit administration will review the DFPS concerns to determine if any action required." There was no documentation showing follow-up to these concerns in the investigation file. o For DFPS case #38520585, the DFPS investigator recommended staff training in regards to alternate behavioral interventions that might have diffused the situation leading to an altercation between two individuals during the incident. The facility UIR included a recommendation for unit administration and the CC supervisor to discuss options that may be available in terms of behavioral intervention. There was no documentation in the investigation file showing that this had occurred. The facility maintained a log of completed and incomplete follow-up to recommendations given in investigations. A review of the facility log of incomplete recommendations from 6/14/10-1/30/11 indicated that there were numerous outstanding recommendations that had not been followed up on by assigned staff. The facility needs to ensure that follow-up action is taken and documented when appropriate. The facility was not in compliance with this provision.	
	(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.	Based on review of MSSLC Incident Management policy Item V.D, the policy did not require that records of every investigation are to be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the facility, investigation files were maintained in the investigator's office. Files requested during the monitoring visit were readily available for review at the time of request.	Substantial Compliance

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		With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team. The facility policy needs to be updated to reflect requirements for maintaining investigation files.	
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 had a system in place to track data on unusual incidents and investigations. Data were compiled in a numerous logs requested by the monitoring team that included: • 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 compiled quarterly reports that focused on all unusual incidents, all allegations of abuse and neglect, and all injuries. Trend analysis provided by the facility was last compiled in November of 2010. In order for the facility to be able to identify current trends and address them in a timely manner with a plan of action, these trend reports needs to be reviewed at least monthly. The facility was not in compliance with this provision	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	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility director had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers.	Substantial Compliance

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	directly with individuals living at 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.	Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 50 employees confirmed that their background checks were completed. The information obtained about volunteers was also reviewed. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks annually. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. The facility provided the monitoring team with a list indicating there were 11 applicants who were not hired based on background checks and two employees were terminated due to results of annual background checks. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self-report all criminal offenses. A sample was requested for 24 employee's acknowledgement to self-report criminal activity forms. The form was available for 23 of the 24 (96%) employees in the sample. The facility was in compliance with this provision of the Settlement Agreement.	

Recommendations:

1. Ensure that all employees receive annual training as required by state policies on abuse and neglect and incident management.
2. The facility needs to ensure notification is made to all parties required within required timeframes in regards to investigations.
3. The facility needs to ensure that the facility policy addresses qualifications for all staff responsible for completing investigations.
4. Ensure investigation reports include a summary of the investigator's analysis of the history of the alleged victim and alleged perpetrator if relevant to the current investigation.
5. The facility needs to ensure all investigations are promptly 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 should be noted and addressed by the reviewer.

6. Include evidence in PSPs that information on identifying and reporting abuse and neglect is shared with individuals and their LARs.

7. The facility needs to ensure that documentation reflects the day that the investigation concluded. The facility investigator should sign the report upon review.

8. The facility needs to develop recommendations to address any follow-up action that needs to be taken following the conclusion of the investigation. Date of completion for follow-up action should be documented in the investigation file.

9. The facility policy needs to be updated to reflect requirements for maintaining investigation files.

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:** Documents Reviewed: o DADS policy #003: Quality Enhancement, dated 11/13/09 o MSSLC QA policy, Administrative-37, 3/9/11 o MSSLC QA Plan, 3/9/11 o Organizational chart, 2/15/11 o MSSLC policy lists, 2/17/11 o List of typical meetings that occurred at MSSLC o MSSLC POI, 2/24/11 o MSSLC QA Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/14/11 o Set of tools used by the QA staff (three) o Set of blank statewide self-monitoring tools used by the service departments o Table showing service department and QA scores on self-monitoring tools o Table and graphs of one of the QA tools (the four-part MSSLC quality assurance monitoring tool) o MSSLC trend analysis report, January 2011, for four areas: restraint usage, abuse and neglect allegations, incidents, and injuries o Statewide data elements table o Risk management report, November 2010 o MSSLC QA Report, 1/12/11, 11/10/10 o PET meetings for PET I, PET II, and PET III: monthly minutes from each PET from November 2010 through February 2011 o PET III meeting agenda and handouts for 2/17/11 meeting o QAQI Council meeting minutes: 11/3/10 through 3/16/11 (10 meetings) o Corrective action plans (five) o DADS MSSLC family satisfaction survey online summary, nine respondents o Documents related to immediate jeopardy finding by DADS regulatory 3/3/11 through 3/17/11 o MSSLC CMS ICFMR review report, 8/20/10 o Presentation materials, ICF Survey Process and Current Issues, by Colleen Range, 2/3/11 o Staff suggestion box follow-up and summary information o Flyer asking staff to identify problems for workgroups to address o Self-advocacy meeting minutes and notes, monthly, 10/10 to 3/11 (six meetings) o Examples of summary notes from home meetings for individuals (four) Interviews and Meetings Held: o Colleen Range, Director of Quality Enhancement o Dr. William Lowry, Facility Director o Brenda Shoemake, Assistant Director of Programs

	o Etta Jenkins, Settlement Agreement Coordinator o Barbara Shamblin, Bertha Allen, John Parks, Troy Miller, Polly Bumpers, Residential Unit Directors o Individual #95 (self-advocacy meeting leader) o Lloydette Harris HRO, and Lynda Mitchell Assistant Ombudsman 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 QAQI Council Meeting, 3/16/11 o Facility senior management meeting, 3/15/11 o PET III meeting, 3/17/11 o Self-advocacy meeting, 3/17/11
	Facility Self-Assessment: The facility completed its self-assessment for this provision, called the POI. The POI had been extensively revised since the last monitoring review as noted in the Monitor's executive summary above. The facility rated itself as being in noncompliance with all five items of this provision. The monitoring team concurred with the facility's self-ratings for all of these provision items. The narrative portions of the POI provided a good description of the activities that the QA department had conducted since the previous onsite review. There were a number of action plans and they referred back to many, but not all, of the recommendations made in the previous monitoring report. The comments seemed reasonable and pointed to the activities and actions the facility was planning to take towards meeting those outcomes of the POI. In addition, the presentation book prepared by the facility for this section of the Settlement Agreement was reviewed. Although not a requirement of the Settlement Agreement or the monitoring team, the facility's intention was for the presentation books to be an easy way for the monitoring team to learn about progress and activities of the department in relation to this provision. MSSLC should update its POI based upon the information presented by the monitoring team during the onsite review, at the exit conference, and in this report.
	Summary of Monitor's Assessment: MSSLC was not in compliance with any of the items of this provision, however, progress had been made since the previous review and the QA department's activities appeared to be pointed in the right direction towards eventual substantial compliance. The QA director had initiated a QA policy, QA plan, and QA report. She supervised a team of competent and hard working QA staff and worked closely with the

	Settlement Agreement Coordinator and her staff. This state policy was being revised. The monitoring team hopes that the new statewide policy will provide specific direction to all of the SSLCs so that there is consistency in expectation regarding a number of areas, such as the format and content of the QA plan and QA report, and the use of PETs. Facility-specific policy called for each service department head to collect, analyze, and act upon quality assurance data collection procedures in his or her own department, but did not give any guidance on how to do so. Specific guidance, and perhaps training, should be provided. The QA department needs to take a more comprehensive approach to managing data at the facility. This includes • Creating a listing of all data collected at the facility that includes data collected by each service department and by QA department staff, and that is in line with the areas in the guidelines written by the Assistant Commissioner. • Determining which of these data are to be submitted to the QA department for tracking and trending, included in the QA report, and presented to QAQI Council. The facility was using a set of self-monitoring tools that were designed to be used at all of the SSLCs. The monitoring team, however, recommends that the facility and state work with the monitoring teams to review and update the state-created tools so that they are based upon the most recent findings and activities of the monitoring teams. Self-advocacy meetings present another way of obtaining information that may be useful to the QA department and facility management. It did not appear that MSSLC was meeting the self-advocacy needs of the individuals, as evidenced by poor attendance and participation, somewhat irrelevant topics, and absence of any teaching of problem solving and decision-making. On the other hand, residential services had recently initiated home meetings for individuals that allowed for small group discussion around issues and activities more pertinent to the individuals. These home meetings present an excellent opportunity for the facility to have an appropriate outlet for assessing and addressing satisfaction issues and for teaching self-advocacy problem solving skills. Two QA reports were submitted to the monitoring team that were one page long and were more of an agenda for the QA director's presentation at the QAQI Council than they were a report that would be useful to senior management. The QA director should look to central office for direction on the contents and format of an adequate QA report. The QAQI Council meeting observed by the monitoring team did not include a review of any provisions. It is hoped that once data are presented, more discussion and decision-making will occur as intended by the designers of the QAQI Council and as indicated in the guidelines from the DADS Assistant Commissioner. Consider that the QAQI Council is one of the few times during the month when the senior management of all of the service departments are together.

	MSSLC had an active set of Performance Evaluation Teams. During each meeting, the service department head presented updates and information regarding progress towards achieving substantial compliance as well as the results of implementation of the self-monitoring tools and the comparison to the QA department's implementation of the same tools. Five CAPs were being implemented at the time of this onsite review. The organization and presentation of the CAPs was another improvement since the previous onsite review. The monitoring team has a number of considerations for the facility as it moves forward with meeting this requirements of this provision item.

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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.	MSSLC's QA program had improved and advanced since the previous onsite review. New facility QA policies, processes, and activities were in place and, although only recently initiated, these actions were taking the QA program in the right direction towards substantial compliance. <u>Policies and QA Planning</u> The DADS statewide policy #003: Quality Enhancement, dated 11/13/09, was adopted by the facility. This state policy, however, was being revised and was likely to be disseminated some time in the next few months. The facility will likely benefit from receiving additional direction via this new policy. The monitoring team hopes that the new statewide policy will provide specific direction to all of the SSLCs so that there is consistency in expectation regarding: • Facility-specific policies • Format and contents of the QA plan o Minimum required types of data • Utilization of statewide self-monitoring tools • Facility-specific self-monitoring tools • Formation and utilization of PETs • QAQI Council responsibilities • QA reports • Corrective Action Plans In addition to the state policy, MSSLC had developed and implemented a facility-specific policy regarding quality assurance titled Quality Assurance, and numbered Administrative-37. It was approved by the facility on 3/9/11. This was one of the department's accomplishments since the last onsite review. The policy attempted to outline some of the facility-specific actions related to quality assurance. It is likely that this policy will need to be revised once the updated statewide policy is disseminated.	Noncompliance

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		The policy included a requirement that the facility service department head for each Settlement Agreement provision be responsible for the implementation of the state policy for that provision as well as for the development of quality assurance procedures for that provision. This was very good to see and showed that the facility was taking steps to make quality assurance a facility-wide activity. The policy called for each service department head to be "responsible for analyzing the data for their department/division" (page 3, paragraph IV.B.1.c.3), and to "develop and implement a corrective action plan to address problems identified during the analysis of collected data" (page 4, paragraph IV.B.1.d.1). The policy did not, however, give any guidance on how the department head was to do either of these actions. Specific guidance, and perhaps training, should be provided. The policy also referred to a Quality System Audit Report (page 4, paragraph IV.B.1.c.5), but this was not described in any documentation or during any discussions during the onsite review. Thus, it was unclear if this was to be the QA report, or if it was to be some other document. The policy also required the QA department to "Monitor MSSLC compliance with federal and state regulations on an on going basis" (page 5, paragraph IV.D.1.a.). This seemed to be a very large task, but no details were provided as to how the QA department was to do this. The policy (and resultant practices) will also need to be updated as the facility moves towards a more comprehensive quality assurance program. To do so, the QA department needs to think broadly about data collection and data usage. The monitoring team had the opportunity to discuss this at length with the QA director during the onsite review. To summarize, the QA department needs to: • Create a listing of all data collected at the facility that includes: o Data collected by each discipline service department; this includes two categories of data: ▪ Data the discipline service department uses for its own service and operational purposes ▪ Data the discipline service department collects as part of its own self-monitoring and which includes these two categories of self-monitoring tools: • Statewide self-monitoring tools • Facility-specific tools created by the MSSLC service department o Data collected by the QA department staff: ▪ Data they collect themselves (three forms were used)	

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		▪ Data that are the result of the QA department's interobserver agreement (reliability) assessments of the service department's own self-monitoring o Data from the areas listed in the Assistant Commissioner's guidelines for QAQI Council, such as Life Safety Code, ICFMR regulatory activities, and the FSPI. • Determine which of these data are to be submitted to the QA department for tracking and trending. • Determine which of these data are to be o Included in the QA report. o Presented regularly to the QAQI Council. QAQI Council should make this determination, that is, it should not be a decision made by the service department head or by the PET. • Create and manage corrective actions based upon the data collected and direction from the QAQI Council. <u>QA Department</u> Colleen Range was the QA director. She began in this role shortly before the previous onsite review and as noted above, had engaged in a number of activities to move the QA program forward during the past six months (e.g., QA policy, QA plan, QA report). The other members of the QA department had not changed since the previous onsite review. Overall, the monitoring team found the QA staff to be competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. The facility was fortunate to have these staff members (Karen Wilson, Kim Kirgan, Terri Moon, Danny Watson) and the monitoring team appreciated their time during the onsite review. The facility should consider ways of supporting the continued professional development of the QA staff regarding generally accepted professional standards in quality assurance in the field of developmental disabilities (e.g., readings, texts, workshops, invited presentations). Etta Jenkins, the Settlement Agreement Coordinator, played a lead role in the collection and organization of data and documents at MSSLC so that the monitoring team could conduct its review. Ms. Jenkins worked tirelessly to provide the monitoring team with information during the weeks before, during, and following the onsite review were much appreciated. She was competent, well organized, and professional. She was assisted by Bobbie Hall and Sandy German who were also helpful and responsive to the monitoring team's many requests. The QA department might also benefit from taking some specific steps to more fully integrate into the overall operation of the facility. The monitoring team suggests that the	

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		QA director and SAC contact the QA director at the Lufkin SSLC regarding some of that facility's activities. These are also summarized in the October 2010 compliance monitoring report for Lufkin SSLC. <u>Quality Assurance Plan</u> The development of an initial QA plan was another of the department's accomplishments since the last onsite review. Although the QA plan was not complete, it contained a great deal of information and was a reasonable beginning upon which to build a full QA plan. In order to do so, guidance will need to be provided from the soon-to-be-revised statewide QA policy (as noted above) regarding content and format. Second, the QA plan should be informed by having the QA director (and perhaps QAQI Council) review the full listing of all the data being collected at the facility (as also noted above) to ensure all relevant data are included in the QA plan. Third, the MSSLC QA plan was a spreadsheet listing a variety of data, but it needed to include a brief narrative that told the reader how it was developed, how it was updated, and the meaning of the rows and columns. The MSSLC QA plan spreadsheet was eight pages long. Each row was for a specific self-monitoring tool and each column provided direction regarding the implementation and use of the self-monitoring tool, such as the person responsible to implement it, the specific tool to use, the frequency of implementation, the sample size, and the person responsible for managing the findings. There were a set of rows for many (but not yet all) of the provision items of the Settlement Agreement. Following this were rows for many of the facility's own self-monitoring tools and some for service department data. It was not clear to the monitoring team if all of these data (i.e., for every row in the QA plan) were submitted to the QA department for tracking and trending or if this was the beginning of the comprehensive list of all types of data being collected at the facility. Regardless, it was a good start and as the QA department proceeds, it should separate this as indicated above in this section. <u>QA Activities and Indicators</u> The activities of the QA staff were primarily • Collection of data using their own forms: o QA Monitoring Form (engagement, home environment, programming, community activities) o Unit Incident Management/Morning Meeting (newly developed) o Mealtime observations • Completion of service department self-monitoring tools for the purpose of assessing interobserver agreement • Participation on various committees and attendance at various meetings	

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		The QA director presented the monitoring team with a set of self-monitoring tools that corresponded to many of the provisions of the Settlement Agreement. Each tool consisted of a set of checklist-type items and had an attached set of instructions for completing each item of the tool. These tools were designed to be used at all of the SSLCs, were generated by DADS central office, and were based upon a set of tools originally used by the monitoring teams and developed in 2009. At the time of this onsite review, there were tools for 12 of the 20 provisions of the Settlement Agreement. Most provisions had one tool; there were 12 for nursing care and three for most integrated setting practices. Tools were going to be created for the other eight provisions though, at this time, the facility was using the monitoring team's original tools. It was good to see that tools had been standardized for use by all the SSLCs and that they were based on the monitoring team's original tools. The monitoring team, however, recommends that the facility and state work with the monitoring teams to review and update the state-created tools so that they are based upon the most recent findings and activities of the monitoring teams. In the baseline report and in the last monitoring review report, the monitoring team recommended that a variety of satisfaction measures be obtained as part of the QA system at MSSLC. Some progress had occurred and some activities were just beginning. First, the staff suggestion box continued to be active. Each week, facility management reviewed and discussed each item and a response was recorded in a new spreadsheet table. The facility should create some sort of data to track these suggestions, such as the number per month and the category of the topics raised by staff. These data could then be part of the QA program and thereby regularly reviewed by QA and the QAQI Council. Also, the assistant director of programs began a process to obtain suggestions from staff for which work groups would be formed. Both the suggestion box process, and the ADOP's planned workgroups appeared to be worthwhile activities. DADS should consider ways of sharing of best practices across SSLCs because different activities occur across the SSLCs and it is likely that QA directors would appreciate learning from each other. The DADS two-year survey from February 2010 was not reviewed because it was discussed in the previous report. The monitoring team suggests that the facility start to think about the next implementation in February 2012 and ways in which it might utilize those data once they are obtained. Second, DADS had recently initiated a survey of satisfaction of family members and LARs. The monitoring team was pleased to see this new activity. One-twelfth of the families	

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		and LARs were to be surveyed each month (i.e., around 50 per month at MSSLC). Responses could occur via a paper format or via an online format. As of the week of the onsite review, only nine families/LARs had completed the survey. Three were from the Martin Unit, one from Barnet unit, three from Shamrock, one from Whiterock, none from Longhorn, and one did not indicate a unit. Seven of the nine were families of individuals who had resided at MSSLC for more than five years. This represented a very small and limited response and, therefore, more months of data will be required before any generalized assumptions or findings can be made. Even so, the respondents provided very interesting comments for many of the questions (both positive and negative) and the facility should review each of these comments and follow-up as appropriate. Third, a measure to survey the satisfaction of related community agencies, providers, and vendors was not yet in place. The monitoring team continues to recommend doing so. Fourth, as also noted in the previous monitoring review report, self-advocacy meetings present another way of obtaining information that may be useful to the QA department and facility management. It also can provide a context in which individuals can be taught group problem solving and decision-making skills. Self-advocacy minutes for five monthly meetings, 10/10 to 2/11 were reviewed and the self-advocacy meeting on 3/17/11 was observed by the monitoring team. Attendance was low (about a half dozen individuals) at each meeting, except for the meeting where they discussed keeping the on campus canteen open for longer hours. The meeting observed by the monitoring team consisted of a detailed presentation by the on campus vocational director regarding MSSLC job support options. It did not appear that the self-advocacy group was meeting the self-advocacy needs of the individuals as evidenced by the poor attendance, somewhat irrelevant topics, and absence of any teaching of problem solving and decision-making. On the other hand, residential services, under the direction of the ADOP, had recently initiated home meetings for individuals that were called "Peer Review Meetings." These were held once to twice per week and allowed for small group discussion around issues and activities more pertinent to the individuals. As a result, individuals were more likely to attend, participate, and find the activity meaningful. These home meetings present an excellent opportunity for the facility to have an appropriate outlet for assessing and addressing satisfaction issues and for teaching self-advocacy problem solving skills. As noted in previous reports, an additional suggestion is to include in this meeting the teaching (and learning) of a structured group problem solving process, such as: • Define the problem in objective terms. • Generate two to four possible solutions.	

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		• Discuss the pros and cons of each solution. • Vote to choose a solution to implement. • Develop a plan to implement the solution. • Develop a plan to report on the results of implementation of the solution.	
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. MSSLC was not in compliance with this provision item, however, progress had been made since the last onsite review. <u>QA Data Management and Analysis</u> A well-designed QA report may help the QA department to manage all of the data collected via its QA policy and QA plan. At the time of this onsite review, the QA department managed data in the following manner. First, the QA director recorded the monthly data from the four-component QA Monitoring Form in a table. She recently began to graph these data, too. The data, however, were not shared or used by the facility. Second, data from a three-page spreadsheet called the "data elements table" were recorded and were submitted to DADS central office, but were not used in any meaningful way by the QA department or by facility management. Both of these sets of data, should be incorporated into the overall QA plan as described above. There was no indication that the other QA-collected data (i.e., mealtime, unit meetings) were summarized or managed in any organized manner. Third, data from each service department's own self-monitoring (using the state's self-monitoring tools) were submitted to the QA department and were averaged into a single metric (e.g., 92%) and placed on a spreadsheet called "Total Compliance by the Month Summary." Data collected by QA department staff on the same measures were also placed into this spreadsheet showing the comparison between the service department and QA department scores. This was an attempt to demonstrate interobserver agreement. The next task is for a reliability calculation to be made to indicate the percentage of tool items upon which there was agreement. Another next step is for the facility to ensure that service department and QA department staff are using criteria that look at quality of the items on the checklist tool, not only whether or not they are present in the record (a member of the PET III meeting also made this comment during the meeting). This spreadsheet was also a good first step in organizing and managing what will eventually be a large set of data. A great deal of additional work will be necessary to provide the reader with detail as to what the numbers mean, the size of the sample, the percentage of agreement, and the follow-up to disagreement in scoring. Each row of this	Noncompliance

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		spreadsheet should be updated to reflect the revised set of statewide monitoring tools for each Settlement Agreement provision. Further, each row should also appear in the QA plan spreadsheet. Fourth, the trend analysis, a statewide activity that reported on four areas (restraint, abuse and neglect allegations, unusual incidents, and injuries) continued to be managed by the director of the quality services division. This continued to be an excellent set of data and should be incorporated into the overall QA plan at the facility (even if it continues to be managed by the current director). The development of procedures, standards, and criterion to analyze data, summarize the findings, and create a useful QA report will be required for the facility to meet this provision item. <u>QA Report</u> A QA report had been developed and its existence demonstrated another area of progress. It was only recently developed, and was going to be reviewed and expanded. Nevertheless, even though inadequate, it represented a good start from which a more comprehensive and useful report could be created. Two QA reports were submitted to the monitoring team (1/12/11 and 11/10/10). Both reports were one page long and were more of an agenda for the QA director's presentation at the QAQI Council than they were a report that would be useful to senior management that included, for example, a description of the QA department's activities and the current data for some of the data that QAQI Council wanted to regularly review (see E1 above). The QA director should look to central office for direction on the contents and format of an adequate QA report. <u>QAQI Council</u> The QAQI Council had met regularly, approximately two times per month, since its inception in November 2010. Minutes from 10 meetings were reviewed (including minutes for the meeting attended by the monitoring team) and indicated a range of topics, primarily related to administrative, regulatory, and Settlement Agreement areas. It appeared, however, that the meetings were used to make announcements and provide information to the attendees rather than for discussion regarding quality enhancement and facility improvements. The facility's plan, however, was for each QAQI Council meeting to have a standard agenda of regular topics (e.g., status of regulatory deficiencies) and a rotating agenda of a set of Settlement Agreement provisions that corresponded with the way the provisions	

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		were assigned to each PET (see below). The rationale was to allow for a more meaningful discussion of a smaller set of provisions and their related data. This appeared to the monitoring team to be a reasonable way to proceed (though it was not yet being implemented). The QAQI Council meeting observed by the monitoring team did not include a review of any provisions. Further, there was little discussion of any topic; instead it contained only a presentation of information. It is hoped that once data are presented, more discussion and decision-making will occur as intended by the designers of the QAQI Council and as indicated in the guidelines from the DADS Assistant Commissioner. Consider that the QAQI Council is one of the few times during the month when the senior management of all of the service departments are together. In addition to the QAQI Council, the facility director also held a weekly meeting of his senior management staff. The meeting presents an opportunity to more in depth discussion of some of the data and topics raised at the QAQI Council. <u>Performance Evaluation Teams</u> MSSLC had an active set of Performance Evaluation Teams numbered I, II, and III. Each of the teams had responsibility for a set of the 20 Settlement Agreement provision items. During each meeting, the service department head presented updates and information regarding progress towards achieving substantial compliance as well as the results of implementation of the self-monitoring tools and the comparison to the QA department's implementation of the same tools. This was a different use of PETs than at other facilities. In most other facilities, PETs were formed in response to a need for corrective action. The monitoring team liked MSSLC's use of PETs and recommends that the state consider this as a best practice to be considered by other facilities. <u>Corrective Action Plans</u> The QA department had begun to try to track corrective action plans. The department used the state policy CAP tracking spreadsheet. Five CAPs were being implemented at the time of this onsite review: • Mealtime errors 9/3/10: in response to QA department staff observations • Funds management 10/22/10: in response to a DADS audit • Fire safety 1/19/11: in response to the state fire marshal survey • Unauthorized departures 12/10: in response to a DADS regulatory review • Nursing services 2/21/11: in response to DADS finding of immediate jeopardy	

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		The organization and presentation of the CAPs was another improvement since the previous onsite review. The monitoring team has a number of considerations for the facility as it moves forward with meeting this requirements of this provision item. These considerations could be included in MSSLC's facility-specific policies regarding QA and the QAQI Council. • How to determine whether or not corrective action is required (e.g., based on scoring of a monitoring tool, based on a level of data submitted, based on discussion at QAQI Council). Note that only one of the five CAPs was generated by the facility. The other four were generated by external reviews and surveys. • If there is a determination that corrective action is required, describe what that action will be. A formal Corrective Action Plan (CAP) is one possibility, but there are other types of corrective actions that might be more appropriate (e.g., development of a new policy, decision by facility director). • Create a method for tracking all corrective actions, not only corrective actions that require a CAP. • A corrective action, whether it be a CAP or not, may involve the formation of a Performance Improvement Team (PIT). A PIT, once formed, might also delegate certain activities to a Performance Evaluation Team (PET). • Specify how the facility's practices for implementing corrective actions will meet the requirements of the items of this provision, that is: o E2: 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 o E3: disseminate corrective action plans o E4: monitor and document implementation and outcomes of the corrective action o E5: modify corrective actions when needed.	
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

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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 new DADS policy once it is disseminated.
2. The new state policy should provide specific guidance to the facility in, at a minimum, the areas listed in the second paragraph of section E1.
3. Revise the facility-specific policies based upon the new DADS policy, once it is disseminated.
4. Ensure that service department heads know how to analyze data and create corrective actions when needed (as required by the facility's own policy).
5. Provide detail on how the QA department is to monitor the facility's compliance with federal and state regulations (as required by the facility's own policy).
6. Create a comprehensive approach to organizing the facility's data for QA purposes, as detailed in E1. This includes creating a listing of all data collected at the facility, determining which of these data are to be submitted to the QA department, and determining which of these data are to be in the QA report and presented to QAQI Council.
7. Develop an adequate and comprehensive QA plan.
8. Update all statewide self-monitoring tools.
9. Include suggestion box information in the QA program; create a metric and summary of the suggestion box submissions.
10. Obtain a larger response from LARs and family members to the facility's satisfaction survey; review and follow up on any specific comments, as appropriate; incorporate the data into the QA program.
11. Measure satisfaction of community affiliated agencies, providers, employers, health care providers, and so forth.
12. Evaluate whether the current self-advocacy activities are meeting the needs of individuals at the facility, including whether they are learning how to make decisions, solve problems, and advocate effectively.
13. Develop the QA report into a comprehensive and useable document.
14. Ensure reliability assessments of service department self-monitoring tools are done correctly, that an agreement calculation is made, and that

criterion refers to quality of the item, not only to its presence or absence.

15. Ensure QAQI Council addresses all of the required topics as per direction from the DADS Assistant Commissioner for the SSLCs.

16. Ensure that QAQI Council engages in meaningful discussion about relevant topics.

17. Develop a comprehensive system to generate, implement, manage, and track corrective actions, as per E2 through E5, and as described above.

The following are offered as additional suggestions to the facility:

18. Engage the QA staff in professional development activities related to quality enhancement.

19. Consider other activities to integrate QA more fully into the facility. The monitoring team suggests that the QA director contact the QA director at the Lufkin SSLC.

20. Share successes and best practices regarding staff satisfaction across SSLCs.

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 Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o Supporting Visions Training Curriculum o MSSLC List of PSP development dates and admission dates o The following documents for a sample of individuals: • Individual #401 – PSP dated 2/1/11, Assessments, SPOs • Individual #53 – PSP dated 2/2/11, Assessments, SPOs, BSP • Individual #132 – PSP dated 1/10/11, Assessments, SPOs, BSP • Individual #251 – PSP dated 2/7/11, Assessments, SPOs, BSP • Individual #383 – PSP dated 1/13/11, Assessments, SPOs, BSP • Individual #289 – PSP dated11/18/10, Assessments, SPOs • Individual #228 – PSP dated 1/12/11, Assessments, SPOs • Individual #548 – PSP dated 1/25/11, Assessments, SPOs • Individual #313 – PSP dated 2/2/11, Assessments, SPOs, BSP • Individual #113 – PSP dated 1/26/11, Assessments, SPOs • Individual #226 – PSP dated 2/11/11, Assessments, SPOs • Individual #356 – PSP dated 2/8/11, Assessments, SPOs • Individual #497 – PSP dated 1/25/11, Assessments, SPOs • Individual #40 – PSP dated 8/18/10, Speech Assessment • Individual #175 – PSP dated 1/20/11, Assessments, SPOs • Individual #72 – PSP dated 12/8/10, PSPAs • Individual #508 – PSPA dated 2/8/11 • Individual #259 – PSP dated 7/7/10, PSPA dated 1/10/11 • Individual #360 – PSP dated 10/19/10 o Records listed in section M, J, O, and P <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, 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 Charles Bratcher, Quality Services Director o Pat Samuels, Incident Management Coordinator

	Observations Conducted: o Observations at residences and day programs o Daily Incident Management Review Team Meeting 3/14/11 and 3/15/11 o Behavioral Therapy Committee Meeting 3/14/11 o Restraint Reduction Committee Meeting 3/16/11 o Human Rights Committee Meeting 3/15/11 o Shamrock Unit Meeting 3/15/11 o Quarterly PST meeting for Individual #225 o Annual PSP meetings for Individual #374 and Individual #413
	Facility Self-Assessment: The facility's POI and interviews with the QMRP Coordinator indicated that the facility was in agreement with the monitoring team's assessment of this area. Progress in this area since the last monitoring visit was based on completion of training on the new PSP process and beginning implementation of the process during annual PST meetings. The facility reported that it was focusing on deficits noted in Section F, but acknowledged that many of these efforts are in the beginning stages.
	Summary of Monitor's Assessment: Compliance with section F of the Settlement Agreement will require the facility to complete thorough assessments in a wide range of disciplines to determine what services are meaningful to each individual served and what supports are needed to allow each individual to fully participate in those services. Plans will need to be developed that offer clear directions for staff to provide supports deemed necessary through the assessment process and then a plan to monitor progress will need to be implemented so that plans can be updated and revised when outcomes are completed or strategies for implementation are not effective. Monitoring of plans will need to include a mechanism for ensuring that assessments are revised as an individual's health or behavioral status changes, and then outcomes and strategies will need to be revised in plans to incorporate any new recommendations from assessments. Finally, a service delivery system will need to be in place that addresses supports determined necessary by each PST. The DADS policy for this section had been revised and approved 7/30/10. The forms and instructions relative to PSP development had been revised prior to the monitoring team's visit. According to the facility's POI, QMRPs had attended training on developing person centered plans and had begun to implement the new process at annual PST meetings on 1/1/11. All staff at the facility were required to complete training on the new person centered process by 12/21/10. PST meetings observed the week of the monitoring visit were in the new style format. At the PSP meetings observed, team members discussed supports needed in relation to the individual's

	preferences and interests. The new format of the plans indicated that there were some very positive changes occurring in PSP development that would lead to individuals having plans that were useful guides to staff supporting the individual on a daily basis. Information regarding supports that the individuals needed throughout the day was more clearly stated in the newer PSPs. As noted throughout section F, while there was positive movement towards integrating supports throughout each individual's plan, there was not much progress being made on developing plans that would lead to a more meaningful day for individuals. Teams were restricted by the lack of program options offered at the facility and very little consideration was given to programming in the community. The facility offered very few options in terms of programming. The majority of individuals at the facility either went to school or worked at one of the few jobs offered at the facility. When not in school or working they attended one or more classes offered at the facility. Individual's schedules were not driven by their preferences, but instead by options offered for programming at the facility. Classes were focused on either behavioral interventions identified for a number of individuals at the facility or medication administration and health education (SAM and HIP). Outcomes were almost exclusively focused on SAM and HIP classes. Although these classes offered valuable information that might be needed for individuals living in the community, a review of PSPs and informal interviews with individuals at the facility indicated that many were not interested in attending these classes. Rather than focusing on providing activities and learning opportunities driven by individual's preferences, the facility was implementing a reward system to try to encourage individuals to participate in activities that were offered by the facility. The monitoring team noted that many behavioral issues at the facility appeared to be a result of boredom or lack of active treatment in line with individual's preferences. The current system for developing outcomes for individuals will not be sufficient to address the person centered planning process and meet compliance with the provisions in section F. The QMRP Coordinator was aware of the challenges facing teams in trying to develop person centered plans with few options for implementation of the plans. PSP Coordinators were the team members designated to facilitate meetings and model the new process during the planning stages. In meetings observed, the PSP Coordinators were competent at encouraging team participation and ensuring that all necessary information was covered during the PST meeting. Quality enhancement activities with regards to PSPs were in the initial stages of development. 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. Throughout section F, the monitoring team has focused on trying to provide the facility with examples of where, when applicable, changes have been effective in producing desired outcomes and examples of areas where problems have been identified and will need to be addressed as new procedures are developed. The monitoring team looks forward to seeing how systemic changes will impact specific outcomes for

	individuals once the facility has had a chance to fully implement these changes. The PSPs that were reviewed were primarily chosen from among the list of individuals for whom the new format/process for PSPs had been used. Sixty annual PSPs had been developed since 1/1/11. The monitoring team reviewed a sample of 12 (20%) of the new plans to assess compliance with section F. The sample was selected randomly, and included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QMRPs and PSTs had been responsible for the development of the plans. Since the new plans were so recently developed, additional old style plans were added to the sample in order to look at implementation over a longer period of time.

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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.	PSP Coordinators were responsible for facilitating PST meetings, there were three coordinators employed at the facility. The QMRPs were responsible for developing, monitoring, and revising treatments, services, and supports. All PST meetings observed during the monitoring visit confirmed that PSP Coordinators were facilitating PSP meetings with varying degrees of input from the QMRP assigned to the individual. A sample of PST attendance sheets were reviewed for presence of the QMRP at the annual PST meeting. At 11 out of 12 (92%) annual meetings, there was a QMRP present. Individual #251's PST attendance sheet did not indicate that the QMRP was present at his annual PST meeting. In the annual PST meetings attended by the monitoring team, the PSP Coordinator facilitated the meeting and did a nice job of encouraging input from all team members. The QMRPs appeared to be familiar with the individuals and contributed to the team meetings. See comments throughout this report regarding plan implementation, monitoring of plans, and revision of treatments, services, and supports. It was found that the planning process did not always result in a plan that was developed and accessible to staff responsible for implementing the plan. The facility was not in compliance with this provision.	Noncompliance
F1b	Consist of the individual, the LAR,	A sample of attendance sheets was reviewed for compliance with this provision with the	Noncompliance

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	the Qualified Mental Retardation 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.	following results in terms of appropriate team representation at annual PST meetings. • Ten (100%) of 10 indicated that the individual attended the meeting; • Five (50%) of 10 individuals had an LAR; four of these five (80%) were present at the annual PST. Individual #113's LAR was not present at his annual PST meeting. Staff present by discipline where relevant at the annual PST meeting included: • In nine (90%) of 10, the QMRP attended the meeting, • In eight (80%) of 10, residential staff attended, • In 10 (100%) of 10, day habilitation staff attended, • In one (17%) of six, vocational staff attended, • In 10 (100%) of 10, nursing staff attended, • In nine (100%) of nine, psychology staff attended, • In zero (0%) of five, the psychiatrist attended, and • In four (57%) of seven, appropriate PNM staff attended. • In eight (89%) of nine, appropriate nutritional staff attended. The following are examples of comments regarding participation in PST meetings for a sample of individuals reviewed. • For Individual #401, the signature sheet did not indicate that the psychiatrist attended the meeting or gave input prior to the meeting. The individual's BSP indicated that a reduction of psychiatric medications was being considered. Input from the team would have been useful in guiding this decision. A speech assessment recommended increasing the individual's language comprehension and verbal skills in order to facilitate his need for developing increased interactive communicative skills in settings involving peers. The speech therapist did not attend his meeting and outcomes were not developed to address communication. • For Individual #53, the signature sheet for her annual PST meeting indicated the physical therapist did not attend her meeting. The PSP summarized discussion around mobility supports and made a recommendation for further evaluation. The physical therapist could have contributed beneficial information to this discussion. • For Individual #251, his PSP signature sheet indicated that his QMRP and vocational staff were not present at the meeting. • For Individual #228, his PSP signature sheet did not include home staff, vocational staff, or his psychiatrist in attendance at his annual meeting. His PSP indicated that working was important to him. • Individual #313's annual PST attendance sheet did not include documentation of attendance by his residential staff.	

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		• Individual #113's guardian and psychiatrist did not attend his annual PST meeting according to the attendance sheet. He takes psychotropic medication and has a history of various psychiatric diagnoses. His plan indicated that his behaviors were a barrier to living in a less restrictive environment and resulted in numerous restraint incidents. • For Individual #356, the psychiatrist did not attend his meeting. Given his complex psychiatric needs and risk for polypharmacy, the input from the psychiatrist could have been beneficial in developing appropriate supports for this individual. The SLP was not present at the annual PST meeting to address his communication needs but the plan indicated that communication strategies were discussed. According to his PSP, he was receiving vocational training, but vocational staff did not attend the annual PST meeting. • For Individual #497, the physical therapist was not in attendance at his annual PST meeting. He was receiving psychiatric services and a medication reduction was being considered. The psychiatrist did not attend his PST meeting. • The annual PST meeting for Individual #374 was attended by a team representing several relevant disciplines. He was currently working on campus and a portion of his meeting was dedicated to a discussion around job placement. Vocational staff did not attend his meeting. Input from vocational staff would have been beneficial in the discussion regarding possible employment options. • The annual PST meeting for Individual #413 was attended by all relevant disciplines. 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 each team member who could not attend the individual's PSP meeting. The monitoring team acknowledges that it is not likely that all team members will always be available to meet on any given day. To comply with this provision, the facility will need to develop a system of gathering and documenting input from all relevant team members. The facility needs to focus on improving participation by psychiatry and vocational staff, in particular, when relevant to planning for the individual. The facility was rated as being out of compliance with this provision item.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient	The Personal Focus Worksheet (PFW) was the individualized assessment screening tool used to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. In the plans reviewed, this list was individualized and offered a good starting point for plan development.	Noncompliance

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	quality to reliably identify the individual's strengths, preferences and needs.	Information gathered from the PFW was discussed in the PST meetings observed. Each PSP Coordinator reviewed the individual's list of preferences and members of the team contributed information on how this might be supported. This generally led to discussion and brainstorming by the team on ways to include each individual's preference into his or her day. Preferences for programming were generally a list of activities available at the facility and teams did little to expand outcomes to encourage exposure to new activities in a variety of settings. Outcomes focused on a narrow range of classes and training that were available at MSSLC. Assessments for work and community living did not adequately address the lack of exposure to work and living opportunities. It is essential that assessments provide opportunities for individuals to participate in a variety of experiences relative to areas assessed. Vocational assessments were not adequate to address job placement preferences and skills. Vocational assessments should include situational assessment based on the individual's known skills and interests to determine if the individual is truly interested in possible work in an alternative setting regardless of whether or not the preferred job is available at MSSLC. Some examples where adequate assessments were not completed for the individual included: • The PALS assessment for Individual #401 conflicted with other assessments completed and appeared to be completed without any real consideration of skills that would allow for greater independence in the community. Contrary to his BSP, the PALS assessment indicated that he had no deficits in social skills including expressing his feelings, expressing anger in a non-aggressive manner, and complying with rules and restrictions. These were all targeted behaviors in his BSP. The team determined that priority training for him included sexuality issues, though the PALS indicated no deficits in this area. The person completing the PALS assessment indicated that items did not apply because they were taken care of by maintenance. These skills would be useful when considering community placement. Similarly, many of the skills in the Kitchen Skill section were marked as N/A. The Money Management section indicated that balancing a checkbook, saving money, and banking in the community were skills that he did not need. • Individual #251 had a vocational assessment, but it only addressed a set of eight very basic job seeking skills; it did not address his preferred work interest or work environment. • It was not apparent that a communication assessment had been completed for Individual #228, though his PSP indicated that, "he can speak several words but	

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		is unable to adequately put words together to form sentences." Additional recommendations for communicating with him would have been useful to the team in planning. Work was listed as a priority for him but there was no indication that a functional work assessment had been completed. • There was no indication that Individual #548 had a current neurological evaluation though staff documented a seizure this year and there were references to seizure activity related to behavior issues throughout his psychological assessment. • At the PSP meeting for Individual #374, he informed the team that he did not like his current job. He had not had a vocational assessment completed to identify his skills and preferences. Team members seemed unsure how to address this. After some discussion, the team agreed that they would talk with vocational staff and see if he could try some other jobs at the facility to see if he might be interested in another job. A situational vocational assessment would have served that purpose and should have been completed prior to the meeting so that information about his work preferences could have been integrated into his PSP. • Individual #313's PALS assessment indicated that he had no needs in the area of social skills. This was not consistent with information provided in his psychological assessment. The quality of assessments is thoroughly discussed throughout this report. See sections H and M regarding medical and nursing assessments, section I regarding risk assessment, section J regarding psychiatric and neurological assessments, section K regarding psychological and behavioral assessments, sections O and P regarding PNM assessments, section R regarding communication assessments, and section T regarding most integrated setting practices. 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. Compliance will need to be demonstrated in these other areas regarding the development, monitoring, and revising of assessments in order to achieve compliance with section F1c.	
F1d	Ensure assessment results are used to develop, implement, and revise	A wide variety of assessments were performed prior to PSP development. The older PSP format included a summary of those assessments, while the newer PSPs showed an	Noncompliance

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	as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	attempt to integrate the information into the plan where relevant. As noted in F1c, it was not evident that assessments were always adequate to address needs or were revised as individual's needs changed. A sample of the newer style PSPs indicated that the team was doing a better job at integrating information into a meaningful plan that identified needed supports in relation to the individual's preferences. But as noted throughout section F, planning did not result in a plan that outlined all protections, services, and supports needed by the individual. For example: • Individual #53's plan included a good description of adaptive equipment and supports that she needed throughout her day. She had five documented falls over the past year. The PSP noted that she was at risk for falls and described strategies staff should follow to minimize her risk. • Outcomes in Individual #228's PSP addressed his stated preferences and his PSP included a discussion of supports that he needed throughout his day, however, as noted in F.1.c, he did not have adequate assessments to address all of his needs. • Individual #356's PSP included adaptive equipment and necessary staff support that were identified in his assessments. His behavioral and communication needs were identified in the plan. Outcomes were identified based on his priority needs and preferences. As evidenced by the following examples, assessments often included important information that should have been used as the basis for planning for individuals, however, it appeared that this information was not used to develop and implement protections, services, and supports for the individual. ▪ Individual #401's PSP indicated that a speech assessment included recommendations for increasing his communication skills in settings involving his peers. The team did not develop outcomes to address his communication skills. His speech assessment included the following recommendations (1) Check for understanding by having him verbally repeat directions and/or expectations, (2) give him adequate time to respond to directions and requests, and (3) give him physical and visual cures when giving him instructions for new tasks. These recommendations were not incorporated into teaching strategies in his SPOs. • Individual #53's nursing assessment indicated that her glucose was high in both October 2010 and December of 2010. There was no indication that the team had addressed this issue. • As discussed above, Individual #356's PSP included information from many of his assessments, however, his plan did not include information from his medical	

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		assessment. For example, he had a history of seizures and constipation. This information should have been included in order for staff to monitor his health care needs for signs and symptoms related to areas of risk for him. • Individual #40's PSP indicated that English was his primary language and that he communicated verbally. His speech-language evaluation dated 8/11/10 stated that Spanish should be considered his primary language and that he communicates verbally and with sign language approximations and gestures. The SLP assessment recommended encouragement to use and learn new signs. His PSP did not include this recommendation. • Individual #313's PALS assessment indicated that he had significant needs in the area of community awareness. His PSP did not include any outcomes to address this need. His outcomes focused solely on SAM and HIP objectives. There were many assessed needs that could have been addressed in terms of socialization and community integration. While the facility had made progress in addressing this provision, not all individuals had gone through the new PSP process, therefore, many individuals at the facility did not have plans in place that met this requirement.	
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).	The new DADS policy #004: Personal Supported Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual PSP meeting at minimum. Twelve of 13 PSPs (92%) in a sample indicated that individuals and/or their LARs were offered information regarding community placement as required. Individual #226's PSP did not indicate that information was offered to him regarding community placement. The CLOIP stated that, "due to his tracheotomy, skilled nursing is his only option." It seemed to indicate that she did not think that this service could be offered in the community. Thirteen of 13 PSPs (100%) indicated that community placement was discussed at the annual PST meeting. In all instances, the teams concluded that the individual should continue to reside at MSSLC, there were no referrals made for community placement. The PST annual meeting was observed for Individual #413. The team engaged in a good discussion around living options and appropriate placement in the least restrictive environment. Plans were made for the looking at community provider agencies. Plans did not include strategies for integrating individuals into the community other than to provide opportunities to shop, eat out, and attend specific events. Opportunities to	Noncompliance

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		develop relationships and gain membership in the community were not addressed in any of the plans in the sample. Services were offered based on what was available at the facility. Some examples of priority needs and preferences for individuals that could have been addressed in the community included: • Individual #401 was scheduled to graduate from school in 2012. His plan should have focused on increased community exposure to enable him to move towards community placement. It was not apparent that the team considered supports he may have needed to complete basic tasks in the community, such as working, shopping, banking, or seeking medical care. Other areas that should be considered for training opportunities are relationships and membership in the community. Adequate community based training was not included in his plan. • Individual #175 had an objective to attend community events that she enjoyed. Her assessments indicated that there were many skills that could have been taught while in the community. Strategies could have been developed to make this a more functional outcome. She had an outcome to grasp and hold a key for 10 seconds. The task analysis stated to enhance community awareness. There was no indication that this training would occur in the community and it was unclear how this would enhance her community awareness. • Individual #497 was unable to state his living preferences, he had a wide range of interest that could be supported in the community including going to the movies, eating out, and spending time outside. His outcomes did not include any training to be implemented in the community. Although the facility reported that training was occurring in the community, it was not evident in observations and PSP outcome documentation. Plans will need to include community based teaching strategies to ensure that training is consistent and measurable. While several individuals in the sample expressed a desire to work in the community, there was no indication that steps were actually being taken to secure integrated employment for any of these individuals or that community day habilitation had been considered. This provision is discussed in detail later in this report with respect to the facility's progress in implementing the provisions included in Section T of the Settlement Agreement. There was very little focus on community integration at the facility and teams did not have the knowledge needed to develop plans to be implemented in the least restrictive setting. The facility needs to provide additional training to teams in this area. This is a	

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		repeat need also noted in the previous monitoring report.	
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:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two 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;	The PSPs reviewed included a list of "What's most important to the person?" For most individuals in the sample, this list was used as the basis for outcome development. As noted below, there were some exceptions to this, particularly around preferences for community participation and living options. It was not evident that this list was always the central focus in planning for the individual. Many of the individuals in the sample had the same or similar outcomes based on classes that the facility offered even though as noted below these were not identified as priorities for the individual. There was a significant focus on self-administration of medication (SAM) and health information programs (HIP). During the monitoring visit, it was noted that many individuals expressed dissatisfaction at having to attend these classes. Rather than offer other options for programming, reward systems had been implemented to try to get individual's to attend the class. While the monitoring team acknowledges that information in the class may be a priority for some individuals at the facility, there were many priority skills, such as communication, socialization, and community awareness that were not being taught. Many of these skills could be taught in the community in a more functional way. The facility should consider other training classes that may be more meaningful to individuals at the facility and still offer valuable training that will support the individual to become more independent. This would likely lead to more willing engagement in activities and fewer behavioral incidents. For example, in the PST meeting for Individual #374, he stated that while he refused to attend some training required because he did not enjoy it, he did enjoy the opportunity to attend training related to his interest in music. His PSP contained no reference to attendance at music classes. Activities based on interest and leisure skills offer many opportunities to provide training in a variety of	Noncompliance

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		areas. For example, training on social skills, reading skills, completing task, and following directions are just a few examples of skills that could be taught in a music class. Cooking classes on campus were noted to be one of the favorites for some individuals involved. Again, cooking classes would be a functional way to support individuals to develop a wide range of skills necessary to live more independently. While some of these classes were apparently being offered, there was not a focus on formalized training evident in the PSPs reviewed. Other opportunities for this type of training might include fitness classes, organized recreational leagues, and art classes. While the monitoring team is not suggesting that this type of training take the place of involvement in these type of activities in the community, these training opportunities could supplement training occurring in the community. Teams should use the "What's most important to the person?" section of the PSP to then develop outcomes, include supports that the individual needs to maintain or increase the occurrence of those things in his or her life, and to address any barriers to occurrence. For example: • The PSP for Individual #401 indicated that he would be graduating from school in 2012. As discussed in detail in F1e, his plan did not address assessments and resulting outcomes did not address priority needs. SAM outcomes were considered a priority even though his SAM assessment indicated that he had at least the basic skills to self administer his own medication. For example, he could identify his medications, read the label for instructions, knew the purpose of each, and knew how to safely store them. A priority outcome was developed for stating the meaning of different drug label warnings, though he could read the warnings. Another priority was learning how to refill his prescription even though when assessed, he indicated he would go to the doctor and go to the pharmacy. While additional training might be helpful, spending time in the community learning to access services, including the pharmacy and medical services might be more meaningful. The team did not identify priority outcomes other than those that were offered through SAM and HIP training provided at the facility. Vocational skills were not addressed in his outcomes in his PSP, although if placed in the community, work skills would be a priority. • The PSP for Individual #53 described supports needed throughout her day in a clear manner that support staff could follow. Her outcomes addressed priority needs based on her preferences and identified barriers to becoming more independent. Her PSP indicated that she had visited group homes in the community and expressed interest in moving. According to the PSP, at the time of her annual meeting, she stated that she wanted to stay at MSSLC. The team discussed that fact that her answer to this question changes frequently. Outcomes in her PSP included the opportunity for additional group home tours.	

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		The team might want to consider a trial visit at a community group home in order to provide her with a better understanding of what it would mean to live in a group home. • Individual #132 had an outcome to participate in preferred leisure activities. While it was positive to see the PST include his preferences for music, weight lifting, and listening to books on tape into his outcomes, the team missed the opportunity to incorporate functional learning and community integration into his plan using his preferred activities. Action steps were stated as "he will have the opportunity to listen to music and books on tape and spend time at the gym." The team could have considered action steps that would facilitate community participation while learning valuable skills needed in the community. For instance, researching music events to attend in the community, buying tickets for events, purchasing music at the store, joining a community gym, going to the public library to check out audio books would all have involved functional learning. • Individual #313's PSP did not include any outcomes to be implemented in the community. His PSP described his preferences and interest, but these were not used for outcome development. His only outcomes related to needs identified in his SAM and HIP assessments. There was no indication that his SAM outcomes were a priority for him. He expressed interest in learning to cook, playing basketball, shopping and spending time with family and friends. His PSP did not include any outcomes to support him in becoming more independent in these activities. Some of his SAM and HIP outcomes were identical to the ones in his previous PSP including the strategies for implementation. • Individual #113's PSP indicated that he often refused to attend his SAM class during the past year and stated that he did not like the class, yet SAM objectives were implemented again in his current PSP with no changes in strategies to encourage him to be more active in class or no consideration of deleting the outcome to focus on other outcomes based on his preferences. • Individual #441's PALS assessment indicated that he had no deficits in the section titled Sexuality. He had two training outcomes, one addressed medication administration and one addressed sexuality. Other training that he might need to live more independently was not addressed in outcomes. He had no outcomes addressing community integration. As also noted in section F1e, the PSPs did not address community integration and vocational programming. The facility had few options to address vocational services and discussion of real employment opportunities was not addressed in any of the PSPs reviewed. Individuals at the workshop should have been learning work skills that would	

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		transfer into employment skills for the community with the opportunity to make real wages in an integrated setting. While some plans included opportunities to take trips to the community, and minimal training opportunities in the community, none presented opportunities for participation in a manner that would support continuous community connections, such as friendships and work opportunities. Meaningful supports and services were not put into place to encourage individuals to try new things in the community.	
	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 needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	Outcomes were not always related to the individual's preferences and long-term vision, and plans were not consistent in addressing supports needed to achieve outcomes. Additionally, teams were not consistently identifying measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. Strategies included limited supports needed for implementation, but adequate supports were not always identified in assessments or, if they were identified, they were not included in planning. Some examples of outcomes and goals that were not measurable and/or did not include supports needed to accomplish the goal included: • Individual #548's PSP listed six outcomes including: (1) continue his job on the road crew, (2) participate in community activities, (3) continue investigation of community living options, (4) QMRP will attempt to locate family gravesite, (5) risk assessment to be completed, and (5) continue to assess and train for electronic communication device. None of the goals included strategies for completion and none were measurable so that staff could identify when progress or completion had been achieved. His one SPO addressed money handling skills which was not listed as an outcome in the main PSP document. He expressed interest in living in the community and no barriers were identified, the team did not develop steps to move him closer to achieving his vision. • Individual #113's SPOs did not include behavioral support recommendations in the teaching strategies. Little direction was offered to support consistent implementation of his outcomes. Similar SAM and HIP outcomes were assigned to a number of individuals in the sample. Teaching methods and steps to achieving the outcome were standardized and did not include specific supports needed by each individual. Training was designed to be implemented in the classroom rather than in a more functional setting, such as at home while medications were being administered or in the community at the local pharmacy	Noncompliance

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		where additional skills such as money management and appropriate social interaction could be integrated into learning opportunities. Some examples of outcomes and goals that were measurable and/or did include supports needed to accomplish the goals included: • Individual #53's SPOs were the only ones in the review that included specific supports described in her assessments in the teaching methods. Her teaching methods described both supports needed and barriers to achieving her outcomes. Teaching strategies were adequate to support consistent implementation • Individual #226's SPOs were measurable and included adequate strategies for consistent implementation. As noted in F1e, PSPs indicated that community placement was discussed at PST meetings and in most instances the teams concluded that current placement was optimal for each individual. Plans did not include strategies and supports to be provided in a more integrated setting. Other than going on community outings, plans did not designate that services would be provided outside of the facility, even though a lack of exposure to the community was noted as being a barrier to community placement in some of the plans reviewed. Outcomes to go on community outings did not have corresponding SPOs for learning to take place while in the community. Although an SPO is not required for every outing, the lack of SPOs in this area were missed opportunities for instruction to have occurred.	
	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. PSPs developed using the new person centered training, however, showed progress in this area. The newer plans were much more comprehensive in identifying and addressing risk for individuals and including supports that were needed by each individual. See section I of this report for specific examples of how risks were being identified and addressed in plans. 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. Then the facility must ensure that plans are developed and implemented in a timely manner. As noted throughout section F, the planning process did not always result in a plan being developed and distributed to staff responsible for implementing plans.	Noncompliance

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		In all 30 records reviewed, the nursing assessment and services sections of the individuals' PSP failed to reference their health needs and risks, which significantly impacted upon their daily lives. A review of 30 individuals' PSPs revealed that not one provided even a brief recapitulation of the individuals' health status and progress/lack of progress toward achieving their desired health goals and all failed to reveal any effort to combine and coordinate the individuals' health needs, supports, and services into an interrelated support plan. For example, Individual #17 was a 19-year-old man diagnosed with stage 5 chronic kidney disease and severe dysfunctional elimination syndrome. His health problems, needs, and risks affected every aspect of his life. Nonetheless, the nursing section of his 5/12/10 PSP failed to provide any meaningful, relevant contribution to his support plan. Rather, the section only stated, "HMP should address health care needs in the area(s) of being free of illness." Individual #226's (see J3) PSP information dated 2/11/11 illustrated lack of treatment team integration citing various disciplines' documentation. Individual #197's (see J14) PSP information dated 9/28/10 illustrated lack of individualized treatment planning for individuals prescribed psychotropic medication. PSP language frequently included "the risk of injuries is greater than the risk of side effects from the medication." The PNMP was merely a reference rather than integrated into supports in the PSP. Most of the PSPs reviewed indicated that the PNMP had been reviewed, but without evidence of discussion related to the effectiveness of the plan, modifications that were indicated, and a clear and consistent link to the health risk indicators defined by the PST. This process will be further reviewed when the facility has had an opportunity to fully implement the new person centered planning process.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	PSPs and implementation plans for five individuals (Individual #383, Individual #251, Individual #226, Individual #401, and Individual #53) were reviewed. The following is a summary of what was found: • All outcomes had teaching strategies that included methods for implementation except for Individual #226's outcome to be given the opportunity to attend community events. There were no methods developed for how this would be implemented. • Generic methods were developed that did not include specific supports based on the person's needs. The one exception to this was Individual #53's SPOs. Her SPOs included specific implementation methods that included strategies based on her assessed needed supports. For example, her outcome addressing money skills noted that she might exhibit rage reaction or aggression when she did not get what she wanted. It instructed staff to encourage her to stay focused on her	Noncompliance

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		task. It further instructed, if she appears confused, staff should reorient her to the task with verbal prompts. These instructions were clear enough that all staff could implement her outcomes similarly resulting in consistent measurement of her progress towards achieving her goal. • All outcomes included time frames for completion, however, for three of the five individuals (60%), the time frame was the annual PSP date rather than a date that corresponded with the individual's rate of learning. The team should assign completion dates that correspond with each individual's projected rate of learning. • All PSPs named the staff responsible for implementation of each outcome. Teaching strategies need to be individualized with supports needed based on assessments completed for the individual.	
	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, outcomes in the PSPs reviewed did not always 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 other than outcomes relating to SAM or HIP training. See specific examples in F2a2. The facility was not in compliance 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.	SPOs for five individuals (Individual #383, Individual #251, Individual #226, Individual #401, and Individual #53) were reviewed. The following is a summary of what was found: • All (100%) identified the frequency of data collection • All (100%) indentified the person responsible for data collection • All (100%) identified the person responsible for data review Each SPO included a description of when and where outcomes should be implemented. SPOs named who would be responsible for implementation of each outcome. The monitoring team has given this provision item a rating of substantial compliance because the SPOs identified the data to be collected as required by this provision item. Without making improvements as described in all of the other provisions of section F, this substantial compliance rating will not be all that meaningful to the individuals at the facility. Please also see section S of this report for further discussion of SPO data collection.	Substantial Compliance

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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.	This provision of the Settlement Agreement will also require compliance with several sections throughout this report including confirmation that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services as evidenced in sections J, K, M, O, P, R, and T. Please refer to these sections of the report regarding the coordination of services. The facility is encouraged to implement a monitoring process that reviews which services and supports are needed by an individual and assess whether or not those services are addressed in the PSP. As noted in F2g, the facility did not have a quality assurance system in place to effectively monitor the quality of PSPs. While the monitoring team found a lack of coordinated supports and services throughout the facility, it was evident that the facility was attempting to ensure better coordination among disciplines: • Team members from various disciplines met together to develop the PSP and discuss specific issues particularly around behavioral and health care needs. • As evidenced in the newer style PSPs, teams were engaged in more integrated discussions during team meetings. The monitoring team looks forward to seeing progress made in this area at the next monitoring visit. 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 not in compliance with this provision.	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.	A sample of 40 individual records was reviewed in various homes at the facility. Current PSPs were not available in 26 (65%) of the 40 records, indicating that support staff did not have information necessary to fully implement PSPs. The facility needs to implement a monitoring system to assure PSPs are accessible to all staff providing supports to individuals at the facility. The PSP is a document that is integral to overall service provision, and ensuring it is available in the record seems to be a relatively easy clerical task. 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.	Noncompliance
F2d	Commencing within six months of	A review of records indicated that the PST routinely met to discuss significant changes in	Noncompliance

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	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.	an individual's status, particularly regarding healthcare and behavioral issues. It was not evident that the facility had a system in place to monitor implementation monthly and revise the PSP when outcomes were completed or there was a lack of progress. It was also not evident that teams met when there was lack of progress towards PSP outcomes or when outcomes were completed or no longer appropriate. It was not apparent that outcomes were monitored and revised as needed or that those who were responsible for monitoring plans were retraining staff on implementation if outcomes were not being implemented as written. For example, • For Individual #313, many of his SAM and HIP outcomes were identical to the ones in his previous PSP including the strategies for implementation. For example, his 2010 and 2011 PSP both included the outcome "communicates three consequences of drug under dose to be aware of the effects with no assistance." The implementation strategy was also the same. If he had been working on this outcome for over a year with no progress noted, the team should have met and discussed either discontinuing the goal or developing more effective strategies to teach the skill. • For Individual #259, his PSP noted that he had only met criteria for three of his ten outcomes. There was no indication that the team had met prior to his annual meeting to discuss progress or revise strategies for implementation. Meetings attended during the week of the monitoring visit and a review of PSPs and BSPs in the sample reviewed indicated that when individuals were refusing programming and/or making little progress on outcomes, the PST did not look at whether or not programming was meaningful for the individual, but instead implemented either a reward system for participating in training or implemented restrictions for refusals to attend training. For example, at the PSP meeting for Individual #374, there was discussion regarding his refusal to go to work. The team discussed restrictions that would be implemented (24 hour home restriction) and a ticket based reward system for compliant behavior. This discussion went on for quite some time without the team addressing why he may be refusing to go to work. There should have been some discussion around what type of job interested him or what benefit he might get from working. Receiving tickets for compliance with going to work was not a functional benefit for going to work and did not reinforce employment skills. Receiving pay based on the amount of work completed and then having the opportunity to go into the community and purchase items with money earned would have been a more functional way to teach work skills. From the discussion at the meeting, it seemed that this individual had been refusing to go to work and to the classes that he was not interested in for some time. The team had not met to discuss this and modify his plan prior to his annual meeting.	

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		As the facility continues to progress toward developing person centered plans for all individuals at the facility, QMRPs need to keep in mind that PSPs should be a working document that will guide staff in providing supports to individuals with changing needs. Plans should be updated and modified as individuals gain skills or experience regression in any area. Recommendation throughout this report regarding implementation and monitoring of treatments should be considered when developing the PSP.	
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-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.	In order to meet the Settlement Agreement requirements with regard to competency based training, QMRPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive PSP document. A review of training transcripts for 24 employees indicated that 24 (100%) of the 24 had completed the new training on PSP process entitled Supporting Visions. As noted in F2f, QMRPs were not ensuring that current plans were developed and distributed to staff responsible for providing supports indicating that support staff had not been trained on plan implementation when plans were updated or revised. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised. The facility was not in compliance with this provision.	Noncompliance
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	Of PSPs in the sample reviewed, all (100%) had been developed within the past 365 days. The facility provided the monitoring team will a list of all PSP date, previous PSP dates, and admission dates • 30 were not revised within 365 of the previous PSP • Four were not developed within 30 days of admission.	Noncompliance

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	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.	As noted in F2c, a sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. It was found that 38% of the plans in the sample were not current. Some plans were over a year old indicating that in some cases, PSPs may never have been distributed if developed. This is concerning for a number of reasons. The PSP should be the plan that ensures all support staff have information regarding services, risks, and supports for individuals in the home. Without it, staff do not have the tools that they need to safely and consistently support individuals. One individual (Individual #132) in the sample had been admitted within the past year, and his PSP was developed within 30 days of admission as required by the facility policy. The facility will need to develop a system to ensure that all plans are revised at least annually and put into effect within 30 days of preparation.	
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.	The facility had a tool to monitor PSPs to ensure the development of a comprehensive PSP that addressed all services and supports. 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. QMRPs should be held responsible for not distributing plans in a timely manner and support staff should be trained to notify supervisors when they do not have the tools necessary to safely and consistently provide supports. As noted throughout this section, plans have not been developed that meet the requirements of Section F. An effective quality assurance system for monitoring PSPs was not in place at the facility.	Noncompliance

Recommendations:

1. Develop a system to ensure that PSPs are in individual records and updated as necessary.
2. When key members of the PST are unable to attend meetings, document any attempts to get input prior to the meeting and include recommendations from each team member not present.
3. Provide additional training to PST members on developing and implementing plans that focus on community integration.

4. Conduct comprehensive assessments that identify the individual's preferences, strengths, and supports needed.

5. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed.

6. All action steps should include individualized supports based on assessment for each individual.

7. The team should assign completion dates that correspond with the individual's rate of learning.

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. The nursing sections of the PSPs should provide a brief recapitulation of the individual's status and progress/lack of progress toward achieving their desired health outcomes and provide brief, yet meaningful, comments to promote the integration and coordination of health into their overall support plan.

11. Utilize the psychiatric treatment plan for psychotropic medications in the overall team treatment plan.

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 DADS draft policy #005: Minimum and Integrated Clinical Services o Organizational chart, 2/15/11 o MSSLC policy lists, 2/17/11 o List of typical meetings that occurred at MSSLC o MSSLC POI, 2/24/11 o MSSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 3/14/11 o Documentation for training sessions conducted by the medical director regarding G2, proper handling of non-facility consultations, 12 attendees o QAQI Council meeting minutes: 11/3/10 through 3/16/11 (10 meetings) o Review of records listed in other sections of this report o Documentation regarding psychiatry attendance at PSP meetings Interviews and Meetings Held: o Dr. William Lowry, Facility Director o Delores Erfe, MD, Medical Director o Barbara Shamblin, Bertha Allen, John Parks, Troy Miller, Polly Bumpers, Residential Unit Directors o Etta Jenkins, Settlement Agreement Coordinator o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. o Three meetings with PCPs and facility psychiatrists Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o QAQI Council Meeting, 3/16/11 o Facility senior management meeting, 3/15/11 o Behavior Therapy Committee o Four psychiatry clinics
	Facility Self-Assessment: The MSSLC POI rated G1 and G2 as in being in noncompliance. The monitoring team agreed with these self-ratings, however, expects that the facility will achieve substantial compliance with G2 in the near future. Determination of a set of activities that are required to demonstrate the provision of integrated clinical care

	will likely be required if the facility is to meet the requirements of G1.
	Summary of Monitor's Assessment: MSSLC had made some progress in this provision area, but more work was needed. Progress was seen in the variety and breadth of activities that were occurring across the facility (G1). Numerous efforts had been taken to address the handling of non-facility clinical consultations (G2). A number of specific examples were provided to, or observed by, the monitoring team that showed ways in which MSSLC was making service provision more integrated across clinical service departments. These examples are provided below. On the other hand, there were a number of areas in which integrated services could be, but were not being, provided. A draft of a state policy was reviewed. It addressed a combination of the requirements of both provisions G and H. The content related to section G, however, was merely a restating of the wording from the Settlement Agreement and will, most likely, be insufficient to guide the facility in engaging in those actions that will lead to, and demonstrate, the provision of integrated clinical services. Moreover, without additional guidance, there will be little consistency across SSLCs and little sharing of best practices. As a result, the monitoring team recommends specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring

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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 need.	Although this provision was not yet in substantial compliance at MSSLC, the monitoring team learned about, and observed, a number of efforts the facility had taken, and was planning to take, towards increasing the likelihood that integrated clinical services would be provided to individuals. The monitoring team had the opportunity to talk with the medical director, Dr. Erfe, numerous times during the week of the onsite review, including a discussion specifically regarding provisions G and H of the Settlement Agreement. An overall facility plan was not in place to address this item, although a number of activities were occurring (see below). A facility policy did not exist, however, a draft DADS statewide policy was available. It addressed both integrated clinical services (section G) and minimum common elements of clinical services (section H). The aspects of the policy that addressed section G were minimal and will not likely be helpful to the facility because the policy merely mimicked the wording of the Settlement Agreement without providing any direction to the facility, such as specifying certain required activities to foster integrated clinical services, and providing examples of additional	Noncompliance

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		actions the facility could take to indicate that integrated clinical services were occurring. The medical director and the facility physicians implemented the facility's self-monitoring tools for section G. Since September 2010, one review was conducted by each residential unit's physician (i.e., five per month across the facility). The form was completed and entered into a table format. It was great to see that the medical director and physicians were doing this self-monitoring. The section G self-monitoring tool, however, was based upon the monitoring team's original checklist tool and needs to be revised so that it is useful to the medical department. This tool did not appear to be very useful and, as discussed with the medical director and with DADS state office, the monitoring team recommends that the medical department consider discontinuing this self-monitoring until a more useful tool can be developed. It is likely that this will require the delineation of a set of activities in which the SSLCs are minimally required to engage in order to demonstrate substantial compliance with this provision item. The Monitoring Panel expects to work with DADS and DOJ on this over the next few months. This does not mean that the facility should not work towards providing integrated clinical services, only that the medical department consider temporarily suspending its self-monitoring. The facility should also consider that this provision refers to a variety of clinical services, not all of which are under the supervision of the medical department. Thus, to achieve substantial compliance with this provision, a facility-wide effort will be required. This, therefore, may be another area for a facility performance improvement project or corrective action plan. The involvement of the facility director and the QAQI Council will likely be necessary for the achieving of substantial compliance. Moreover, the facility might consider having the facility director be the lead for this provision item. Examples of integration of clinical services that were observed by the monitoring team, or that were planned to occur, are listed below (in no particular order of importance). • Integrated progress notes were being used. • Daily physician meetings included medical, psychiatry, and nursing. • Psychiatrists were more consistently reviewing the recommendations in the DRRs. • Physicians and pharmacists were collaborating as evidenced by the pharmacy clinical interventions log and review of physician orders. • Caseloads prohibited physician attendance at all PSP addendums. Data, however, indicated improvement in that area. • The medical director arranged for the neurology physician assistant from the local hospital (Scott & White) to visit MSSLC, meet medical staff, and tour campus, 1/12/11.	

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		• A first neurology phone consultation occurred with Scott & White's neurology department, 2/23/11. The plan was for this to occur once per month. • Four FTE psychiatrists were on board at MSSLC, and there were two full time psychiatry assistants. They were being integrated into facility operations. • A psychiatrist attended the weekly Behavior Therapy Committee meeting. The assignment rotated each week so that all psychiatrists were participating and interacting with psychology. • The medical director reported that medical and nursing departments were collaborating to ensure that all physician orders for outside consultations were being completed. • Physicians were attending the NMT meetings. • Physicians were attending more PST meetings. For example, during the week of the onsite review, Dr. Ellis attended an annual PSP meeting and the CLDP meeting. This increased attendance was also noted by the unit directors. • Residential unit directors reported that there had been more talk and focus upon restraints over the past few months and that this involved many departments. • There was some evidence that nursing and the other clinical services collaborated to ensure that individuals received the clinical services they needed. This was accomplished largely through the PSPA process. Other examples indicated that more work needed to be done: • Integration of clinical services was not evident in the written annual PSP document. The narrative should document the team's discussion and illustrate (a) how integration had occurred over the previous year and (b) plans to ensure integration of clinical care was to occur during the upcoming year. In addition, there will continue to be separate plans (e.g., PNMPs, BSPs, nursing care plans), however, the PSPs should identify (in action plans) the objectives of these separate plans, identify who is responsible for implementation, identify who will review data, any modifications of plans, and integration of these plans with other disciplines as appropriate. • Record reviews indicated that the nurse did not always notify the PCP of acute medical problems in a timely manner. • Nursing collaboration with other disciplines was usually limited to episodic reviews of incidents and levels of supervision (although it was occurring as noted above). • Observations of psychiatry clinic revealed lack of clinical leadership. Psychiatry and psychology did not establish a collaborative case formulation for the individual that led to inadequate identification of target symptoms. Nursing staff did not provide pertinent clinical information to the team unless requested to do so, even for individuals who experienced problems with the prescribed	

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		medication regimen. • There was limited collaboration of the development of communication plans between psychology, speech therapists, and residential direct care staff; examples were noted in section R below. • OT, PT and SLP worked in a collaborative manner, however, they did not conduct co-assessment via observation in the home and day programs to identify potentials for skill acquisition plans and methods to enhance existing programs. • There was an absence of necessary data provided in psychiatric clinics for Psychiatrists to make data based medication decisions (see K4).	
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.	The facility appeared to be responsive to recommendations from non-facility clinicians. MSSLC, however, should include in its operating procedures the requirement for an explicit statement, in the integrated progress notes, of the PCP's agreement or disagreement with each of these recommendations, and the requirement to refer relevant information to the PST. The medical director engaged in a number of activities towards this provision item and it is likely that substantial compliance will soon be achieved. First, she conducted two training sessions for medical department staff regarding proper handling of consultations and recommendations from non-facility clinicians. Across two sessions, 12 medical staff attended. The content appeared to be appropriate and included the topic of determining when, and how, to refer the information to the PST. For example, notification could occur via written format, in a small group format, or by calling together the entire PST. One consideration would be if the information required a change in an individuals care plan. Second, the medical director maintained a report log that listed all non-facility consultations and tracked them from the date received until the final report was obtained. This listing might be useful to the recordkeeping department for their conduct of quality assurance reviews of the active record (see section V3 below). Third, the nursing department was tracking faxed physicians' orders at the unit level to reduce the likelihood of any being missed. Fourth, a dedicated fax machine was obtained. This helped with the management of non-facility consultations (and was noted as a problem and recommendation in the previous monitoring report). Fourth, external audits monitored compliance with this requirement. That audit documented compliance in the 20 charts reviewed.	Noncompliance

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		The only evidence of nurses' reviews of recommendations from non-facility clinicians was the presence of reports from the Hospital Liaison. The Hospital Liaison ensured that individuals who were hospitalized and receiving services from non-facility clinicians were monitored on a regular basis. The information obtained from her monitoring activities was documented in the individual's record and shared electronically via email. The Hospital Liaison's duty to ensure that important clinical information, data, and recommendations were gathered from non-facility clinicians was the Nursing Department's single, largest contribution to help achieve integration of clinical services. There was little other evidence that nurses regularly and consistently reviewed non-facility clinician's consultation and evaluation reports and/or assessed and evaluated the impact of their findings on the individuals' responses to their health problems and needs.	

Recommendations:

1. Develop and implement policy.
2. Add to the draft DADS policy by specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring.
3. Considering temporarily suspending self-monitoring of section G until a revised and more useful self-monitoring tool is developed.
4. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.
5. Review and consider addressing the many items above in G1 under "Other examples indicated that more work needed to be done."
6. Include a statement regarding the integration of clinical services in each individual's PSP document.
7. Consider having the facility director be the lead for this provision.
8. Nurse managers and case managers should document their review of non-facility clinicians' reports and what actions they take (or recommend) to evaluate the individuals' response to the findings/recommendations of non-facility clinicians and to promote their health, safety, and well-being.
9. Psychiatry and psychology should begin to form collaborative case conceptualizations and jointly determine psychiatric target symptoms to be monitored. Psychiatry should be consulted regarding non- pharmacological interventions.
10. For most effective implementation and consistency of methods used across environments, co-assessment should occur via observations across a variety of settings. This will permit a more integrated approach to the development and the implementation of communication plans.

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 DADS draft policy #005: Minimum and Integrated Clinical Services o Organizational chart, 2/15/11 o MSSLC policy lists, 2/17/11 o List of typical meetings that occurred at MSSLC o MSSLC POI, 2/24/11 o MSSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 3/14/11 o Documentation for training sessions conducted by the medical director regarding G2, proper handling of non-facility consultations, 12 attendees o QAQI Council meeting minutes: 11/3/10 through 3/16/11 (10 meetings) o Review of records listed in other sections of this report o Documentation regarding psychiatry attendance at PSP meetings Interviews and Meetings Held: o Dr. William Lowry, Facility Director o Delores Erfe, MD, Medical Director o Barbara Shamblin, Bertha Allen, John Parks, Troy Miller, Polly Bumpers, Residential Unit Directors o Etta Jenkins, Settlement Agreement Coordinator o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. o Three meetings with PCPs and facility psychiatrists Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o QAQI Council Meeting, 3/16/11 o Facility senior management meeting, 3/15/11 o Behavior Therapy Committee o Four psychiatry clinics
	Facility Self-Assessment: The MSSLC POI indicated that all seven provision items were not in compliance, and noted some comments regarding activities that were occurring towards meeting each provision item. The monitoring team concurred with these ratings as indicated below.

	Summary of Monitor's Assessment: Some progress was observed in regards to this provision item. First, a draft state policy was reviewed. Although it was not yet completed, it provided some detailed guidance to the facility regarding provision H (but not for provision G as noted above). It will be important for the facility to include all clinical services, not only medical services, as it works towards addressing the requirements of this provision. 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. It is recommended that the facility's QA department play a role in addressing 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.	An overall facility plan was not in place to address provision H of the Settlement Agreement and, therefore, a plan was also not in place to address this provision item. That is, 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. Medical assessments, evaluations, and care were occurring as reported by the medical director and as commented on in section L of this report below. Moreover, the medical director reported that the medical department tracked all annual assessments monthly and alerted the appropriate physician of any delinquent reports as well as those that were due for the upcoming month. She said that they tried to take care of any delinquencies within 30 days. That was good to hear. A method to ensure this provision item was being addressed across <u>all</u> clinical service areas, however, was not yet in place (e.g., also see sections J, K, M, O, P, Q, and R). According to the medical director, physicians conducted sick call/clinic daily. A list was maintained on each home. Annual medical assessments were completed and included a plan of care for medical problems. The monitoring team found several deficiencies related to the plans missing active diagnoses and subsequently corresponding plans of care. For example, there were several instances in which a diagnosis, such as constipation dysphagia or heart failure, was not included as an active problem and plans were, therefore, lacking. A draft DADS state policy was available and this was an improvement since the last	Noncompliance

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		onsite review. It addressed provisions G and H together. The policy was not yet completed or disseminated. The majority of the policy addressed section H and appeared to be a good start to providing the facility with some guidance and direction. It might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of provision H. As noted above in section G, the facility medical staff was also doing self-monitoring of section H. Since September 2010, a review of one individual's record was conducted by each of the five unit physicians. At this time, the self-monitoring did not appear to provide the medical and clinical staff with useful information and the monitoring team recommends that the facility consider temporarily suspending this self-monitoring until a more useful and detailed tool is developed. For this provision item, H1, the state policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). At MSSLC, the medical director reported that physicians were being reminded to fill out the Hospital Discharge Form after every hospital stay, the new psychiatrists were given the template for completing initial psychiatric evaluations, and a copy of the article on how to bio-psychosocial formulations was distributed as a guide for treatment planning and case formulation. Hospital return forms were being completed, but the documentation was often minimal despite of prolonged and complicated hospital stays. There was a significant, persistent pattern of failure by nurses to appropriately respond to significant changes in individuals' health status (see section M). This included failure of LVNs to promptly notify nursing supervisors and/or physicians of significant changes; failure of RNs to promptly respond to LVNs calls for assistance in assessment and evaluation; and failure of nurses, in general, to critically evaluate and appropriately respond to indicators of significant change in health status. Psychiatric evaluations had not occurred on a regular basis. Per interview with the facility psychiatrists and upon observation of the psychiatric clinic process during the monitoring review, appointments were frequently changed and, often, when the appointment was scheduled, the individual did not show for the examination the meeting was cancelled.	

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		In regards to psychology assessment, not every individual had a psychological assessment, not every individual with a PBSP has a functional assessment, and functional assessments are not modified on a regular schedule, or when necessary (see K5). In habilitation therapies, assessment conducted due to changes in status were generally limited to discipline-specific consult reports rather than comprehensive and integrated assessment across team members including OT, PT and speech clinicians.	
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 Related Health Problems.	There was no policy in place to require or guide the activities required to meet this provision item. MSSLC was not tracking or monitoring this requirement. Record reviews indicated that appropriate ICD-9 nomenclature was used. Diagnostic terminology appeared to be consistent with ICD standards. Code numbers were not yet being used consistently; this was now also required in the new state draft policy. Medical diagnoses appeared to clinically fit the physician's corresponding assessments and evaluations. The only breakdown noted in this process was when physicians were not provided with accurate health information. For example, Individual #154's nurses failed to notify her physician in a timely manner of her persistent signs and symptoms of a urinary tract infection, which was resistant to treatment with the prescribed antibiotics, because she was already "on antibiotic." Individual #120's nurses failed to report to the on-call physician that during her evaluation in the emergency room she had a chest x-ray (that indicated possible inflammatory infiltrates). Thus, Individual #120's physician called her primary physician and reported, "…I can't explain her lethargy. Will ask staff to review…" After a five-day delay, Individual #154 was prescribed antibiotic and nebulizer treatments. In psychiatry, there was insufficient documentation and lack of case formulation to justify the assigned diagnoses. Psychiatric target symptoms associated with an established DSM-IV-TR diagnosis were rarely highlighted, per record review, as the indication for the selected medication. As outlined throughout section J, the PST concentrated efforts on targeting behaviors such as sexually inappropriate behavior, agitation, and aggression without an explanation of what variables accounted for the individual's presenting symptoms.	Noncompliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions	MSSLC did not have a plan or procedure in place to ensure or monitor that treatments and interventions were implemented timely and were clinically appropriate. The facility did not, at the time of this onsite review, have a way to manage this requirement across all clinical service areas. Current self-monitoring needed to be made more useful and	Noncompliance

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	shall be timely and clinically appropriate based upon assessments and diagnoses.	appropriate (see H1 above). Revisions should consider including an item indicating whether there were any examples of interventions being clinically inappropriate and/or provided later than clinically appropriate. The draft state policy listed eight areas of treatment that were to follow various national and/or state guidelines. A ninth area referred to the federal government's guidelines website. Physicians responded to reports of change in status. There were, however, several cases in which the physician elected to treat an individual at MSSLC when immediate acute care may have been more appropriate. The medical director was aware of this and was addressing the issue. The physicians responded promptly to the recommendations of pharmacists regarding treatment in drug regimens. Twenty-five of the 30 comprehensive nursing assessments failed to reference complete, accurate nursing diagnoses in order to derive adequate interventions to ensure the development of appropriate plans of care that promoted positive outcomes. In addition, nursing diagnoses were not formulated in conjunction with significant changes in individuals' responses to actual and/or potential health problems. The current psychiatrists had inherited a number of individual cases from prior treatment providers. They were attempting to review the diagnostics and the medication regimen. Given the issues with polypharmacy and some of the complicated medication regimens, increased collaboration with psychology and nursing was warranted as well as with the PST to collaborate on non-pharmacological interventions.	
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.	Some activity had occurred at MSSLC regarding the determination of clinical indicators and appropriate clinical protocols. Most notable was the development of a number of protocols developed as part of the statewide program to develop a set of clinical protocols for different medical conditions. MSSLC had focused upon developing the protocols for SIB and pica. The facility had not implemented any of these clinical indicator protocol guidelines at the time of the review. Several had been developed and were being reviewed by state office. The draft state policy included a relatively long list of data for the facility to collect and monitor in areas of medical staffing, timeliness of actions, equipment and resources, quality of care severity indices, expected death rates, morbidity, clinical indicators for a variety of conditions, diabetes care, and patient satisfaction. This looked like a good start	Noncompliance

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		to assist the facility in meeting this, as well as the other, items of provision H. A review of 30 individuals' records revealed that nurses' decisions to "resolve" their follow-up of significant changes in individuals' health status were entirely based on a reduction of observable signs/symptoms of illness versus individuals' achievement of positive health outcomes. The psychiatrists had not identified the time period for expected pharmacological benefit. This provision would require the collaborative development of psychiatric target symptoms for monitoring to establish efficacy of psychotropic medication based on evidence-based practice. There were very few intervention plans developed by OT, PT, and speech, and very few of those included measurable goals with performance criteria. None were outlined in the PSP as training objectives. While documentation was generally consistent it did not clearly relate to a goal as a result and initiation, continuation or termination from therapy was not well justified. 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.	
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. Even so, the medical director noted that each individual's health was observed (i.e., monitored?) every time there was a contact with the physician. Recently, the way in which the facilities determined and managed risk was overhauled. The health status team system was discontinued and managing risk was incorporated into the PSP process (see section I below). Development of state policy may help guide the facility in the determination of a system to effectively monitor the overall health status of individuals, not just their levels of risk. This might include a combination of a variety of information already collected by medical, nursing, pharmacy, and other departments at MSSLC, such as the annual and quarterly medical assessments, nursing assessments, and pharmacy reviews. The activities noted in the draft state policy commented on above in section H4 also apply to this provision item. Across the 30 individuals' records reviewed, the only evidence of a on-going system of monitoring health status was when there was evidence that physician's orders to	Noncompliance

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		monitor particular health status indicators (e.g., weight, vital signs, blood-sugar levels (as applicable) were implemented. Nurses notes failed to reveal that they regularly and/or consistently applied nursing clinical judgment and decision-making such that individual-centered, creative, and intuitive nursing interventions were implemented to effectively monitor individuals' health status. The PST confused the concept of only reviewing medical data at the "Quarterly" instead of when it was clinically appropriate. Medical data should drive the selection of the psychotropic regimen that impacts the psychiatric health status of this individual (e.g. an individual with hypertension and prescribed an antihypertensive agent by the PCP may experience serious drug-drug interactions and side effects if the psychiatrist also prescribed another antihypertensive off-label for an Axis I Diagnosis). The results of the findings in the psychiatric consultation regarding this provision should become part of the other disciplines' focus of health status as well to ensure continuity of care.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	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 response to clinical indicators. A comprehensive set of clinical indicators had not been established. Numerous clinical guidelines were being reviewed at the state level (see L2). It was not clear that PBSPs were modified based on individual behavior (K5) There was, however, evidence that SPOs were modified based on the performance of individuals (see S3).	Noncompliance
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 provisions of Section H.	Policies, procedures, and guidelines were not in place regarding Section H and, therefore, this provision item was found to be in noncompliance. State policy was in draft and incomplete format. Comments are provided above in H1 through H5 and are not repeated here. The Medical Services policy (i.e., section L) based on state issued policy and the Health Care Guidelines had been implemented. Training rosters were provided for physician attendance at several in-services related to newly implemented medical and pharmacy policies.	Noncompliance

Recommendations:

1. Develop and implement policy. Specifically indicate in the policy how it addresses each of the seven provision items of provision H.
2. Ensure that all clinical services are addressed by the facility, not only medical activities.
3. 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.
4. Take steps to ensure that nursing diagnoses are always related to each individual's nursing assessment to promote health and safety and reduce the risks of misdiagnosis and inappropriate interventions.
5. Considering temporarily suspending self-monitoring of section H until a revised and more useful self-monitoring tool is developed.
6. Involve the facility's QA department in the many monitoring and data tracking activities that will be required to increase the likelihood of meeting the requirements of this provision.

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 #006.1: At Risk Individuals dated 12/29/10 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Risk Assessment Tools, dated 8/31/09 o DADS Integrated Risk Rating Form o DADS Quick Start for Risk Process dated 12/30/10 o DADS Risk Action Plan Form o DADS Risk Process Flow Chart o DADS Risk Guidelines date 12/20/10 o List of individuals seen in the ER or hospitalized since 1/1/10 o List of individuals with fractures since 1/1/010 o List of individuals with pneumonia incidents in the past 12 months o List of 10 individuals with the most injuries o List of all individuals residing at MSSLC and their risk rating levels o List of individual diagnosed with dysphagia o List of individuals with challenging behaviors o List of individuals at high risk for respiratory issues o List of individuals at high risk for choking o List of individuals at high risk for GI concerns o List of individuals at high risk for aspiration o List of individuals that have contractures o List of individuals at risk for falls o List of individuals at high risk for skin integrity issues o List of individuals diagnosed with pica o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals at high risk for osteoporosis o List of individuals diagnosed with seizure disorders o List of individuals at high risk for seizures o List of individuals with poor oral hygiene o List of individuals requiring meal time assistance o List of individuals at risk for weight loss or weight gain o List of individuals receiving enteral feeding o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers 1/1/10 – 1/31/10 o List of top ten individuals causing peer injuries for the past six months. o PSPs and assessments for: • Individual #313, Individual #53, Individual #497, Individual #175, Individual #441,

	Individual #228, Individual #401, Individual #383, Individual #548, and Individual #342 o Informal interviews with various individuals, 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 Charles Bratcher, Quality Services Director o Pat Samuels, Incident Management Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Daily Incident Management Review Team Meeting 3/14/11 and 3/15/11 o Behavioral Therapy Committee Meeting 3/14/11 o Restraint Reduction Committee Meeting 3/16/11 o Human Rights Committee Meeting 3/15/11 o Shamrock Unit Meeting 3/15/11 o Quarterly PST meeting for Individual #225 o Annual PSP meetings for Individual #374 and Individual #413
	Facility Self-Assessment: The facility POI indicated that the facility was not yet in compliance with the provisions of section I. Notations in the POI indicated that the state office had provided At Risk webinar training for various disciplines at the facility on 01/13/11. The facility acknowledged that it was in the initial stages of implementation of the new at risk process that was designed to meet the provisions of section I. The POI indicated that teams continued to meet, discuss risks and develop plans to reduce risk. The facility acknowledged that the new process had only been in place for a short time period and teams would need more time to "get accustomed to changes." The monitoring team agrees with this assessment.
	Summary of Monitor's Assessment: The state had taken a number of steps to support positive results in the area of risk management. This included: • The state policy addressing risk had been revised. It was approved 12/29/10 and implementation began prior to the monitoring visit at MSSLC. The new policy included changes in evaluating and addressing risks identified for individuals. • Forms had been revised for identifying risk, and a risk action plan had been developed. • Risk Guidelines had been developed to be used by PSTs in rating risk factors. • A new initiative was being implemented to address aspiration pneumonia. A tool had been developed to identify individuals at risk for aspiration. <u>Risk categories included Seizures, Challenging Behaviors, Fluid Imbalance, Osteopenia/Osteoporosis, Skin</u>

	Integrity, Weight, Respiratory compromise, Constipation/Bowel obstruction, Falls, Fractures, Aspiration, UTIs, Polypharmacy/Side effects, GI Concerns, Cardiac Disease, Circulatory, Diabetes, Choking, Hypothermia, Infections, and Dental. The at-risk process underwent significant revision designating each individual's PST responsible for risk assessment and management, as well as ongoing risk review and addressing changes in status. Not only would the PST identify health and behavioral risks and their level of severity, but would assure appropriate plans were developed and implemented as planned in order to reduce risks and improve quality of life. The revised at-risk process identified collaboration and assistance with the BSC and PNMT in developing plans for individuals at high risk, who were not stable or for whom the team has requested assistance. Implementation of the revised process began in late January 2011. Training on the new process was provided, but not to all staff. Training was not competency based, even for the PST leaders, the QMRPs. 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 hope is that this process will more accurately describe risks for particular individuals and ensure services and supports necessary to protect each individual will be put into place.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The new state policy, At Risk Individuals 006.1, required PSTs to meet to discuss risks for each individual at the facility. The facility was mandated to have its risk assessments/risk ratings using the new At Risk Process completed at each of the regularly scheduled next quarterly PST meeting held between 1/1/11 and 3/31/11. The at-risk process was to be incorporated into the PST meeting and the team was required to develop a plan to address risk at that time. The determination of risk was expected to be a multi-disciplinary activity that would lead to referrals to the PNMT and/or the behavior support committee. A list of indicators for each of 21 risk areas had been identified by the new state policy and each was to be rated according to how many risk indicators applied to the individual's case. The new policy had expanded the number of risk areas being addressed by this process to include choking, aspiration, respiratory compromise, weight, cardiac disease, circulatory, constipation/bowel obstruction, diabetes, gastrointestinal problems, osteoporosis, seizures, skin integrity, infections, polypharmacy, challenging behaviors, falls, fractures, fluid imbalance, hypothermia, urinary tract infections, and dental status. A risk level of high, moderate, or low was to be assigned for each category. Observation of annual PSP meetings scheduled the week of the review showed that PSTs	Noncompliance

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		had just begun this new process and were still experimenting with how to integrate the new risk identification process with the new PSP development process. PSP coordinators were responsible for attending meetings and facilitating the risk discussion. At meetings observed, the monitoring team observed some meaningful multidisciplinary discussion occurring during each of the PSP meetings observed. Teams were attempting to identify risk and weave that information into the discussion regarding supports needed for the person to achieve their desired outcomes. Individual #225's risk ratings were reviewed at his quarterly meeting during the monitoring visit. There was discussion around his challenging behavior and whether or not the team should assign a moderate or high rating in this area. The team changed his risk rating for challenging behaviors from moderate to high and increased his risk rating for injuries to moderate due to injuries that might occur during times when he exhibited challenging behavior. He was living in a locked home due to his challenging behaviors which would indicate that he was at high risk. The team discussed his health issues and assigned appropriate risk ratings in each area. The individual contributed to the discussion regarding his needs. The meeting was a good example of integrated discussion among disciplines to identify all areas of risk and ensure plans were in place to address risks. An annual PSP meeting was observed for Individual #374 during the monitoring visit. The team reviewed his healthcare issues with the nurse leading the discussion by reviewing any healthcare concerns from the past year. Other team members contributed appropriately to the discussion. The team talked about supports that were needed to address issues identified. For example, the nurse noted that his last labwork results indicated his platelet count was low. The team discussed the fact that it was probably due to his medications. The team agreed that his medication was appropriate, but they would need to continue to request routine labwork and monitor the results. He was at moderate risk for oral hygiene. The team offered some good suggestions for encouraging him to brush longer. It was agreed that a three month dental recall would be beneficial to address this concern also. The PSP coordinator did a nice job of leading the discussion and moving the team along different topic areas. A sample of 10 new style PSPS developed using the new person centered planning process was reviewed to determine if risk were being properly identified by PSTs. • The PSP for Individual #313 stated that he was not at risk for any medical issues. A review of his medical assessments confirmed this rating. His PSP included a good discussion around his risk for challenging behaviors and supports that he needed to address behaviors. His PSP notes that challenging behaviors are the only barriers to living in a less restrictive environment. The log provided to the	

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		monitoring team of each individuals risk levels across all areas, however, indicated that he was at low risk for challenging behaviors. This score should accurately reflect the actual risk described in his PSP. • The PSP for Individual #53 described some risks and supports necessary to minimize her risk for health and behavioral incidents. According to the risk level list provided to the monitoring team, she was at medium risk for aspiration and low or no risk in all other areas. Discussion in her PSP indicated that she was blind and at risk for falls. She had outcomes to address this risk. Documentation indicated that she has sustained injuries due to falls over the past year. She was rated at low risk for falls. This did not appear to be an accurate risk rating. The team should discuss this further and review injuries to determine an accurate risk rating. The PSP did not reflect her medium risk rating for aspiration. The physical and nutritional management section of her PSP did not discuss diet modifications and risk for aspiration. The plan did note in the discussion around community transition that there were concerns that movement into the community might give her free access to food not on her ground diet and put her at risk for choking /aspiration issues. By not addressing her risk for choking and describing support necessary throughout her day, the facility was placing her at risk for choking and aspiration. • The overall risk rating list indicated that Individual #497 was at medium risk for GI concerns, osteoporosis, and skin integrity. All other areas were rated as either low risk or no risk. His PSP indicated that he had lost 40 pounds over the past year going beyond a planned 10 pound weight loss addressed by diet. The plan accurately identified a medium risk for weight loss. This was not reflected on the overall risk rating list. His plan also indicated that he was at medium risk for choking due to pica and chewing tobacco while eating. GI concerns, osteoporosis, and skin integrity was not addressed as concerns in his PSP. His medical assessment did indicate that he had a history of chronic constipation which would have confirmed the risk for GI concerns. • The health risk rating list indicated that Individual #175 was at medium risk for injuries, seizures, and weight concerns. Her PSP stated that her health status was moderate, but then went on to describe multiple medical concerns, including an aspiration risk due to enteral feedings, seizures, osteoporosis with a fracture sustained during transfer, hyperlipidemia, constipation, skin integrity, and ear infections. Even with a diagnosis of osteoporosis and a recent bone fracture, she was rated as no risk for fractures. The overall risk rating list indicated she was at low risk for aspiration, though her PSP did not support this. • Individual #441 was identified at being at moderate risk for challenging behaviors, infections, skin integrity, and weight issues. The health care ratings were consistent with information in his PSP. His rating for injuries and	

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		challenging behavior was not supported by information included in his plan. His plan noted that he was hospitalized for psychiatric instability in the past year and he currently requires enhanced supervision due to challenging behaviors. This information would indicate that he was at high risk for challenging behaviors. He had a recent serious injury related to a behavioral outburst. • The PSP for Individual #228 indicated that he was at risk for choking and osteoporosis. It included strategies to address both risk. • The risk rating list indicated that Individual #401 was at low or no risk in all areas except for challenging behaviors. He was rated as a moderate risk in that one area. His PSP and assessments supported this determination. • Individual #383 was rated as no or low risk in all areas according to the list provided to the monitoring team with all risk ratings for each individual. His PSP supported all ratings except for the rating of low risk for challenging behaviors. His PSP indicated that he displayed significant behaviors that prevented him from living in a community setting. This would indicate that he was high risk for challenging behaviors. • Individual #548's PSP indicated that he was at no or low risk in all areas except seizure activity. Information documented in the PSP and medical assessments supported this determination. The overall risk rating list was in agreement with this determination. • Individual #342's Health Risk Assessment Tool indicated that he was at low risk in all categories. His PSP documented the same ratings, but noted that his only obstacle to community living was his aggressive behavior. His BSP described his challenging behaviors and addressed his aggression. The team needs to assign a rating level to his risk for challenging behaviors that supports assessment information. If the PST does determine that he is at low risk for challenging behaviors this should be removed as an obstacle for community placement and the team should discuss community referral. Numerous additional examples are listed in section M5 below. The facility was not yet in compliance with this provision of the Settlement Agreement, but it was noted that they were attempting to address this provision and put safeguards in place for individuals at the facility. It is expected that all individuals at MSSLC will have gone through the new risk identification process by the time of the next monitoring visit.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year,	The new At Risk policy required that when an individual was identified at high risk, or if referred by the PST, the PNMT or BSC was to begin an assessment within five working days if applicable to the risk category. The PNMT or BSC was required to assess, analyze	Noncompliance

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	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 possible but within five working days of the individual being identified as at risk.	results, and propose a plan for presentation to the PST within 14 working days of the completion of the plan, or sooner if indicated by risk status. As noted in section I1 above, not all risks were identified by the PST. In addition, health risk ratings were not consistently documented. The new procedures of referral to PNMT or BSC had just been implemented at the time of the monitoring visit. 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. 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. The facility was not yet 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 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.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. It required that the PST implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. 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. The new policy requires that the follow-up, monitoring frequency, clinical indicators, and responsible staff will be established by the PST in response to risk categories identified by the team. Throughout the 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 risks or identify supports needed to monitor those risks. Locating "aspiration triggers/aspiration trigger sheets" and specific directions to direct support staff in the individual's notebooks regarding health risks, however, were not consistently demonstrated. As noted throughout this report, intervention plans were often not carried out as written, therefore, individuals remained at risk. Although PSPs included a number of plans to address risk identified by the PST, during observations of homes by the monitoring team, it was noted that PSPs were often missing from individual records, so direct support staff did not have current information	Noncompliance

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		regarding risks available to them. As noted in section F of this report, a sample of 40 individual records was reviewed in various homes at the facility. Current PSPs were not available in 65% of the 40 records. If there is not a current PSP in the home, staff do not have the information that they need to provide safe supports and services to individuals in the home. Staff cannot be held responsible for implementing a plan that they do not have. The facility needs to implement a monitoring system to ensure that staff have information readily available at all times to provide necessary supports to each individual in the home.	

Recommendations:

1. 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.

2. The facility should assure all PSTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the new PSP process. QMRPs/Team leaders should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process.

3. Implement a monitoring system to ensure that direct support staff have PSPs and other plans readily available at all times to provide necessary supports to each individual in the home.

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:** Documents Reviewed: o MSSLC facility policies and procedures manual o MSSLC psychiatry services policies and procedures manual, Medical-17, dated 11/01/10 o Plan of Improvement dated 2/24/11 o MSSLC Presentation Manual for Monitoring Team o Packet prepared for new psychiatry staff containing psychiatry services policies and procedures manual, medical policies, Health Care Guidelines, and audit criteria o Curriculum vitae of facility psychiatrists • Eileen S. Farber, M.D., Kendall P. Brown, M.D., Woodrow W. Coppedge, M.D., and Wanda Jeanne Michaels, M.D. o For the past six months, a list of individuals who received pretreatment sedation medication for medical or dental procedures that included date the pretreatment sedation was administered, the name dosage, and route of the medication, and an indication of whether a plan was in place to minimize the need for the use of pretreatment sedation medication o For the past six months, any auditing monitoring data and/or reports addressing the use of pretreatment sedation medication o A description of any current process by which individuals receiving pretreatment sedation were evaluated for any needed mental health services beyond desensitization protocols o Dental desensitization plans for: • Individual #369, Individual #500, Individual #196, Individual #481, Individual #456, and Individual #335. o Current census counts by home as of 3/13/11 o A spreadsheet of individuals (listed alphabetically) prescribed psychotropic/psychiatric medication, listing name of individual, residence/home, psychiatric diagnoses, and medication regimen (including dosage of each medication and times of administration) o List of all individuals age 18 or younger, including date of birth who were receiving psychotropic medication o A list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and the start date of each medication o Facility-wide data regarding polypharmacy o Spreadsheet for all individuals administered a Reiss screen inclusive of date completed o A list of new admissions since 1/1/10 and date of Reiss screen o List of individuals who (in the past six months) were referred for a psychiatric evaluation as a result of an elevated score on the Reiss screen o A list of individuals prescribed Lithium

	○ A list of individuals with tardive dyskinesia, including: • Individual #521, Individual #248, Individual #462, Individual #518, Individual #239, and Individual #216 ○ Documents listed below for the following Individuals: • Individual #471, Individual #420, Individual #483, Individual #386, Individual #431, Individual #323, Individual #06, Individual #514, Individual #197, Individual #132, Individual #521, Individual #539, Individual #268, Individual #492, Individual #462, Individual #16, Individual #365, Individual #164, Individual #155, Individual #589, Individual #123, Individual #109, Individual #82, Individual #226, Individual #31, Individual #519, Individual #113, Individual #159, Individual #466, Individual #295, Individual #367, Individual #441, Individual #491, Individual #94, Individual #591, Individual #508 • Face sheet • Social history (most recent) • Current personal support plan and addendum • Behavior support plan • Functional behavior assessment • Safety plan • Consent for psychotropics • Rights assessment • Medical and/or dental desensitization plans • Dental section • Restraint section • Physicians annual medical review • Active problem list • Hospital information for the past six months • Health risk assessment tool • Labs for the past six months • Psychiatry section • Side effects screening section (MOSES and DISCUS) • Copy of any adverse drug reaction form completed for psychotropic medication for past 6 months • Quarterly drug regimen review for past year • All medical consults for past year • All neurology consults for past year • Physician orders for past six months • Copy of current medication administration record per pharmacy listing all medications prescribed for the individual at time of this visit • Integrated progress notes for past three months • Comprehensive nursing assessment

	• Reiss screen • Psychology data presented to psychiatrist in psychiatry clinic for each psychiatrist regarding individuals listed in this document request for past three months o Code of Criminal Procedure-Chapter 46B Incompetency to Stand Trial o Article 46B, Code of Criminal Procedure (CCP) Competency to Stand Trial Adult Offenders (MR), Standard Sequence of Events o Chapter 55, Family Code, Fitness to Proceed, Juvenile Offenders (MR), Standard Sequence of Events o Psychiatric quarterly/initial psychiatric evaluation list dated 3/17/11 <u>Interviews and Meetings Held</u>: o Dolores Erfe, M.D., Medical Director o Charlotte M. Kimmel, Ph.D., Director of Psychology o Sulisa Lo, Pharm. D., Acting Director of Pharmacy and Medical Director o Norris Buchmeyer, B.S.N., R.N., Chief Nurse Executive (CNE), and Christine Dalecki, R.N., Nurse Operations Officer (NOO) o Christine Dalecki, R.N., Nurse Operations Officer (NOO) o Group meeting with the Medical Director and the four facility psychiatrists • Eileen S. Farber, M.D., Kendall P. Brown, M.D., Wanda Jeanne Michaels, M.D., and Woodrow W. Coppedge, M.D. o Group Meeting with the four facility psychiatrists o Margaret Michelle Boutte, M.A., psychiatric assistant o John Sponenberg, D.D.S., facility dentist <u>Observations Conducted</u>: o Psychiatric Clinic with Kendall P. Brown, M.D. for the following individual: • Individual #197, Martin o Psychiatric Clinic with Wanda Jeanne Michaels, M.D. for the following individual: • Individual #420, Shamrock o Psychiatric Clinic with Woodrow W. Coppedge, M.D. for the following individual: • Individual #24, Longhorn o Psychiatric Clinic with Eileen S. Farber, M.D. for the following individual: • Individual #98, Whiterock o Behavior Therapy Committee (BTC) for the following individuals: • Individual #431, Individual #161, Individual #268, Individual #539, Individual #159 o Pharmacy and Therapeutics (P&T) Committee Meeting o Physicians' meeting including primary care and psychiatric physicians o Physicians' working lunch including primary care and psychiatric physicians o Medical Review Committee meeting
	Facility Self-Assessment:

	The self-assessment outlined in the Plan of Improvement (POI) for section J, dated 2/24/11 noted a self-rating of substantial compliance in three provisions (J1, J7, and J11). The accomplishments noted in the POI included the hiring of four full-time equivalent (FTE) locum tenens psychiatrists who were either board certified or board eligible, individuals admitted with a psychiatric diagnosis or had a positive Reiss Screen received a comprehensive psychiatric evaluation, and implementation of a review system of polypharmacy data. Based on interviews with staff, observations, attendance at facility meetings, review of documents and policies and procedures, the monitoring team's findings were not congruent with the facility's self-assessment and rated noncompliance with all the provision items for section J. It is hoped that a reading of section J of the report below will provide detail regarding the monitoring team's ratings and the types of actions that the facility needs to take in doing its own self-ratings in the future.
	Summary of Monitor's Assessment: At the time of the visit, the facility had four full-time equivalent (FTE) locum tenens psychiatry staff recently contracted to provide psychiatric services for the individuals at MSSLC. The psychiatrists were learning the system and meeting the individuals assigned to their caseload. The medical director had integrated the psychiatrists with the medical staff by their participation in the daily staff meetings and weekly lunch meetings with the primary care physicians (PCPs). There was no child and adolescent psychiatrist, forensic psychiatrist, and/or board-eligible forensic child and adolescent psychiatrist providing services at MSSLC for the minors at the facility. Minors were admitted for assessment and secondary to court commitment. Upon meeting with the facility psychiatry staff, the monitoring team discovered their understanding of the psychiatric issues outlined in the Settlement Agreement ranged from being unaware of the legal agreement to concerns expressed that "the government," in reference to the monitoring team, "violated HIPAA." The four facility psychiatrists were encouraged to meet together routinely to develop a plan to review and implement the provisions outlined in the Settlement Agreement in order to establish a psychiatric system of care that met generally accepted professional standards of care. While psychiatry was interacting with psychology on some levels, there were marked deficits in the interaction. It was apparent that some of the duties that should fall in the realm of psychiatry were being provided by psychology (e.g. 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 psychiatric clinic was not organized. Space for the psychiatric clinic had not been identified and the schedule was inconsistent, resulting in individuals not being present for their examination. The medical director, director of psychology, and the facility psychiatrists were receptive to working together to

	establish revisions to the delivery of psychiatric services for the individuals at MSSLC.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	There were four full-time equivalent locum tenens psychiatrists. The facility had not designated a lead psychiatrist. MSSLC has history of inconsistent psychiatric staffing and utilized a locum tenens corporation to provide psychiatric applicants. Dr. Farber had been working at MSSLC less than a year and the other three psychiatrists were new to the facility. There were no psychiatrists who were board-eligible or board-certified in child and adolescent psychiatry, forensic psychiatry, and/or forensic and child psychiatry. This was concerning given that there were: • 36 individuals who were younger than 18 years of age who were not receiving psychiatric services from a child and adolescent psychiatrist. • Five individuals under 14 years of age who were not receiving psychiatric services from a child and adolescent psychiatrist. Eileen S. Farber, M.D. was board-eligible in psychiatry by the American Board of Psychiatry and Neurology. Dr. Farber's postgraduate training for psychiatry residency was from 1987 to 1988 at Harvard Medical School-Massachusetts Mental Health Center, and from 1988 to 1991 the remainder of her psychiatry residency was completed at Baylor College of Medicine. Dr. Farber was contracted to work at MSSLC for 40 hours per week. A second full-time psychiatrist, Kendall P. Brown, M.D. was board-certified in adult and geriatric Psychiatry by the American Board of Psychiatry and Neurology. He attended the Medical College of Wisconsin for residency in psychiatry from 2000 to 2004 and began his fellowship training in geriatric psychiatry in 2006. Dr. Brown was contracted to work at MSSLC for 40 hours per week. A third full-time psychiatrist, Woodrow W. Coppedge, M.D. stated that he was board-eligible in psychiatry. Dr. Coppedge's board status was not listed on his curriculum vitae. Residency in psychiatry occurred from July 1996 to June 2000 at the University of Texas Medical Branch in Galveston, Texas. Dr. Coppedge's post-graduate training included a fellowship in addiction psychiatry from June 2001 to May 2002 through the University of Texas Health Science Center in San Antonio. Dr. Coppedge was contracted to work at MSSLC for 40 hours per week. A fourth psychiatrist, Wanda Jeanne Michaels, M.D., was board-certified in psychiatry by	Noncompliance

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		the American Board of Psychiatry and Neurology. Dr. Michaels was contracted for 40 hours per week (three weeks/month). Dr. Michaels' residency training occurred at the University of Texas Health Science Center in Houston, TX from July 1990 to June 1993. She completed an internship in Internal Medicine at St. Joseph's Hospital and Medical Center in Phoenix, Arizona from June 1986 to June 1987. Dr. Michaels noted in her curriculum vitae that she had a special interest in the overlap of medicine, psychiatry, and the law and/or forensic matters related to medicine and had been certified an "expert in forensic evaluation in the State of Texas." The psychiatrist who was board-certified in child and adolescent psychiatry, as well as in forensic psychiatry, resigned since the last onsite review. Per American Academy of Child and Adolescent Psychiatry (AACAP) Policy Statements regarding Criteria for Clinical Privileges for Physician Members of Medical Staffs, the inpatient admission and treatment of adolescents and children should be done only by those psychiatrists who have specific clinical privileges to admit and treat individuals in this developmental age group. • "For patients under 14 years of age, a qualified psychiatrist is a child and adolescent psychiatrist who is board certified in child and adolescent psychiatry or a psychiatrist who in addition to general psychiatry training has successfully completed a training program in child and adolescent psychiatry accredited by the Accreditation Council on Graduate Medical Education." • "For patients 14-17 years of age or older, a qualified psychiatrist is a child and adolescent psychiatrist as noted above or general psychiatrist who has documented sufficient, specialized training and experience in working with adolescents and their families on an inpatient treatment program, and has demonstrated competence to examine and treat adolescents comprehensively." In summary, this provision was found to be in noncompliance because of the (a) the absence of a qualified psychiatrist for those individuals who were under 14, and (b) appropriate consultation/supervision for the psychiatrist treating those who were 14-17 years olds. Please also see the discussion in J5 below.	

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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 staff interviews with the four psychiatrists and the psychiatric assistant, it was reported that individuals receiving psychotropic medication were being scheduled to receive quarterly psychiatric examinations, follow-up evaluations, and a comprehensive psychiatric assessment as outlined in Appendix B. A list of the completed psychiatric quarterly and initial evaluations was provided to the monitoring team. • Psychiatric quarterly/initial psychiatric evaluation list dated 3/17/11 noted 84 initial psychiatric evaluations had been completed for the individuals enrolled in psychiatry clinic at MSSLC. • There were a total of 251 individuals that reportedly required psychiatric at MSSLC as of 3/16/11, therefore, only approximately 33% of the individuals who were prescribe psychotropic medication had received a comprehensive psychiatric examination. The psychiatric assistant has recently been charged with the task to coordinate the psychiatrists' schedule. The facility psychiatrist informed the monitoring team that it was a frequent occurrence for the individual not to show for the psychiatric consultation. To address this problem, two psychiatric assistants were assigned the task of tracking all psychiatric evaluations. This process was implemented 3/1/11. The facility did not have a policy and procedure to specify the details of the clinic operation, such as staff and individual notification about appointment, responsible party ensuring individual's attendance, and how to obtain an appointment with the psychiatrist. Per plan of improvement dated 2/24/11, it was noted that the psychiatric assistants were designated by the medical director to be the "parliamentarian for the psych clinics to lessen the chaos that has been observed in some of those clinics." The monitoring team, however, witnessed the psychiatric assistant failure to know the exact location for the clinic that was to be held and the failure of the individual to be present for the examination. Furthermore, some of the psychiatric clinics observed by the monitoring team occurred in a medical chart room in the residence that was noisy, small, and not conducive to an interview or a meeting. There were varying time periods for the completion of the initial psychiatric evaluation as outlined as well as for the quarterly psychiatric evaluation. Hopefully, timely and routine psychiatric examinations will occur due to the appointment of the psychiatric assistant. Per review of the evaluations that were reviewed by the monitoring team, there were concerns regarding the following: • lack of documentation justifying the listed Axis I diagnosis;	Noncompliance

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		• lack of identification of psychiatric target symptoms associated with the Axis I diagnosis (e.g., target behaviors such as aggression were the basis for medication utilization); • lack of evidence-based practice supporting appropriateness of the prescribed psychotropic medication for the identified psychiatric diagnosis. For example, on 2/3/11, Individual #109's psychiatrist noted five diagnoses in the IPN, yet there was a lack of documentation to justify the listed Axis I diagnoses. This IPN stated that this 13-year-old individual "tried to stab peer with a pencil…says because peer was mean to him. Shows no remorse. Says he wanted to kill him. No remorse-would be happy because then he would be dead. Pt. obviously psychotic, bizarre thought processes. Diagnoses: Bipolar Manic with psychotic features; Intermittent Explosive Disorder; Autistic Disorder; ADHD; Pica. Plan: Increase Geodon for continued psychosis with Bipolar and IED." This individual received an increase in an antipsychotic medication for aggression directed towards another peer that reportedly attempted to harm him. This example did not support appropriate evidence-based practice for this youth receiving an agent, such as Geodon that has numerous potential side effects. Review of the medical data inclusive of vital signs, scales (e.g., DISCUS and MOSES), and laboratory information were not summarized in the psychiatrist's IPN, yet recommendations were to increase the medication without this medical information taken into consideration. There was lack of identification of psychiatric target symptoms associated with the noted Axis I Diagnoses.	
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.	During this review, an interview was held with the director of psychology. A director of psychiatry was not appointed at MSSLC. The medical director, therefore, was the informant for the overview of psychiatric services. Information in the POI dated 2/24/11 summarized that there was "still a need for further cooperation between psychiatry and psychology in formulating a cohesive diagnosis and formulating treatment plans." The facility was in the beginning stages of developing an integrated diagnostic and treatment planning system regarding the psychiatric care of the individuals at MSSLC with the newly hired locum tenens physicians. The monitoring team attended the Behavior Therapy Committee (BTC) held 3/14/11. One of the psychiatrists also attended. This was a rotating assignment across all four psychiatrists. This psychiatrists, however was not familiar with the BTC and PST process and was not the prescribing psychiatrist for the individuals reviewed. As a result, limited information was provided to the BTC by the psychiatrist. This lack of integration negatively effects the decision making process in regards to diagnostics, indications for utilization of psychotropic medication, and/or recommendations of other less intrusive measures. Perhaps some measures can be put in place to prepare the psychiatrist for the	Noncompliance

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		upcoming BTC, such as a listing of the individuals to be reviewed, and each individual's most recent psychiatric note and psychology review. In the records reviewed, there was insufficient information noted in the psychiatric documentation to arrive at a DSM-IV-TR diagnosis, including when a change in diagnosis occurred, deficiency in notation of a pertinent differential diagnostic formulation, and lack of documentation regarding related medication target symptoms to determine medication efficacy. Indications for psychotropic medication were noted to target maladaptive behaviors such as aggression, inappropriate sexual behavior, and self-injurious behavior. If DSM-IV-TR diagnosis was met, utilizing medication that has validated efficacy as supported by evidence-based practice was the appropriate course of intervention in concert with behavioral intervention. Per this provision, psychotropic medications shall not be used as a substitute for a treatment program, or in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis. The facility failed to meet these criteria as illustrated in the following examples: Individual #226 illustrated that MSSLC utilized psychotropic medication in the absence of a psychiatric diagnosis. The indication for medication was "agitation" that was not a DSM-IV-TR diagnosis. This case example also highlighted that a formal BSP was not implemented because MSSLC concluded Individual #226 did not exhibit any "behaviors" that required a formal behavioral support plan. The BSP inappropriately summarized Individual #226 "did not receive any psychoactive medications" and, thus, the monitoring team concluded that medication was being used as a substitute for a treatment program. To further complicate matters, this individual had a seizure disorder and the neurologist was under the impression that Individual #226 received the medication, Lorazepam, as needed, but did not specify the indication for the Lorazepam. Contrary to this, the PCP noted that Individual #226 had Anxiety in addition to epilepsy with documentation as follows: "Anxiety-controlled with Ativan TID." Lorazepam, a benzodiazepine, may serve as an anti-epileptic drug (AED). Individual #226 • Individual #226 received Lorazepam every eight hours for the psychiatric indication of "Agitation." (Agitation is not a DSM-IV-TR diagnosis). • The nursing summary in the nursing assessment dated 2/28/11 noted the following: 2/17/11 Lorazepam was utilized "regarding agitation." • 2/18/11 Nursing summary noted "Lorazepam order should be scheduled; not PRN." • Individual #226's integrated progress notes for past three months and the	

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		psychiatry section of the active record were reviewed. The monitoring team was not able to identify an entry per psychiatry for this individual receiving a benzodiazepine for "agitation" upon review of records provided in the integration progress notes for this period. • Upon review of the PSP dated 2/11/11 it was noted that Individual #226 did not exhibit any behaviors that required a formal Behavioral Support Plan (BSP) or psychiatric services and, further, that this individual did not receive psychoactive medications. There was no Axis I diagnosis. • Physician's Annual Medical Review (Assessment) noted one of the current diagnoses as Anxiety in addition to Epilepsy and in the physician's assessment and plan, "Anxiety-controlled with Ativan TID." • Quarterly Drug Regimen Review completed 7/26/10 indicated that this individual was receiving psychotropic medication with reference to "monthly psychiatry clinic notes." • This individual had intractable epilepsy and was also prescribed Diazepam, another benzodiazepine, on a PRN basis for the indication of seizures. Other medications included Anti-Epileptic Drugs (AEDs) Valproic Acid (Depakote) and Carbamazepine (Tegretol). It was noted that the individual remained "intractable on Depakote and Tegretol polytherapy." • Individual #226 missed a dose of Lorazepam as recorded in the interdisciplinary progress note per nursing staff on 2/21/11. Nursing entry noted "(S) Found extra dose of Lorazepam .5 mg still in drawer. (A) Altered behavior R/T possible agitation. (P) follow-up to monitor change in behavior. • Neurology consultation 9/21/10 noted the individual received other medications, not limited to Lorazepam PRN, but did not specify the indication. Lorazepam, a benzodiazepine, may serve as an anti-epileptic drug (AED), therefore, it was critical for collaboration to occur between psychiatry, neurology, the PCP, and the PST. For example, making one medication change at a time would be advised to avoid causing an individual to experience seizure activity from medication adjustments that lowered the seizure threshold. Individual #591: • Individual #591 was minor who received six of the 29 emergency chemical restraints administered at the facility according to the facility's listing from 8/4/10 through 12/14/10. • A review of his Medication Administration Record (MAR), 2/1/11 to 3/1/11, noted that Paxil was prescribed for sexually inappropriate behavior. • Other medications and indications/diagnoses listed on the MAR included: o Ziprasidone for "Bipolar/Psychosis/Intermittent;"	

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		o Olanzapine for "Bipolar/Intermittent Explosive Disorder." o Divalproex for "Intermittent Explosive Disorder;" o Diphenhydramine for "Extrapyramidal Symptoms;" • 7/27/10 MSSLC Initial Psychiatric Evaluation, per A. Lagrone, MD, noted recommendations "add the diagnosis of depressive disorder NOS", begin trial of Paxil. • 12/29/10 Psychiatry Entry in the integrated progress note summarized that Geodon was increased earlier this month due to continued "aggression toward staff; risk of harm to others, self. Will review: make f/u apt 1-2 weeks." • 1/11/11 Psychiatry Entry in the IPN noted "justification for high Geodon dose recorded earlier 12/29/10. Still justified as staff reports behavior much improved since meds" increased. A little tired, but overall improved…was happy, smile on face…No sustained DEP. Denies A/V halluc…cont. meds-IED." • 2/3/11 Psychiatry Entry in the IPN noted impression was "Bipolar D/O; IED; Psychosis NOS with no medication changes." • 3/1/11 Psychiatry Entry in the IPN noted impression "Sleepy, change Zyprexa to all HS. MSE: Sleepy. Not talking. Info from staff. Clarify DX: Bipolar Manic and change diagnosis 296.44 IED." In order to determine efficacy of the medication regimen, the psychiatrist must establish the psychiatric target symptoms to be monitored. Individual #591 received a significantly restrictive measure of being prescribed an antidepressant medication for "sexually inappropriate behavior." The psychiatrist did not document if this young individual's inappropriate sexual behavior was due to an Axis I disorder such as Bipolar Disorder. There was no case formulation outlining if the individual's presentation was potentially exacerbated with the use of an antidepressant regimen (e.g., medication contributing to a manic state). This individual was prescribed inter-class and intra-class polypharmacy in addition to numerous chemical restraints. The use of medication to suppress sexual drive was a restrictive intervention and must include an informed consent process that specifically outlines the clinical factors justifying selection. Consent procedures mandate informing the LAR regarding clear reasons for utilization of a medication and the risk versus benefit. The Medication Administration Record (MAR), 2/1/11 to 3/1/11, noted that Paxil was prescribed for sexually inappropriate behavior. A consent form for Paxil, however, was not evident anywhere in the record reviewed. There were consents for Geodon and Haldol, with indication of their use for treatment of psychosis, NOS. There was, however, no indication that psychotropic medication was being prescribed as a punishment at MSSLC.	

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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.	Medical staff reported that there were no desensitization plans developed for the purpose of medical procedures. The medical director noted in the POI dated 2/24/11 that each primary care physician (PCP) submitted a list of all the individuals in his/her care who has had a pretreatment sedation for the past 12 months. If desensitization plans were recommended, then a request was to be sent to the psychology department. It was also noted that this list was discussed at the physician's weekly meeting with the facility psychiatrists. There were 38 instances of pretreatment sedation administered 8/10 to 2/11. Reasons listed included dental surgery at another facility, testing (e.g., EKG, mammogram) and medical procedures (e.g., ear irrigation, G-tube removal). An interview was held with the facility dentist. He described informal desensitization procedures that he and the dental staff implemented, such as individuals being scheduled frequently for clinic. Further, the dentist determined what special accommodations might assist individuals with their dental hygiene (e.g., use of non-alcoholic mouthwash for tooth brushing that did not burn, toothpaste taste). Individual desensitization plan for dental procedures were reviewed by the monitoring team with the facility dentist (see list of individuals above under Documents Reviewed). Prior to an individual receiving medication for pretreatment sedation, treatment coordination between psychiatry, PCP, nursing staff, and psychology staff must occur as drug-drug interactions may occur between pretreatment sedation medication and psychotropic agents. The medication effect resulting in a mental status change may be misinterpreted as an exacerbation of the individual's psychiatric condition (e.g., disinhibiting effect of benzodiazepines, such as Ativan). Additionally, an individual administered pretreatment sedation medication superimposed on a polypharmacy psychotropic regimen, may experience alteration of their vital signs, increased lethargy, respiratory depression, and lowering of the seizure threshold, among many other medical complications. In future monitoring reviews, the extent of pretreatment sedation will be further reviewed because the facility was only in the beginning phase of collecting data at the time of this onsite review. The referral process from medical to psychology had been initiated for development of the desensitization plan for the individual for medical procedures.	Noncompliance
J5	Commencing within six months of	At MSSLC, 251 individuals (64% of the census) received psychiatric services at MSSLC as	Noncompliance

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	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.	of 3/13/11. At the time of the previous onsite, there were 224 individuals prescribed psychotropic medication, thus there was an increase of 27 additional individuals who require an initial comprehensive psychiatric evaluation, assessment, and consultation as clinically indicated. A review of the referral process for psychiatric consultation was indicated. There were a high percentage of individuals reportedly requiring psychotropic medication mandating a review of the etiology of the individual's presenting symptomatology (e.g., medical, environmental, avoiding task demands, change of staff). As noted above in section J1, at the time of the review, MSSLC employed four full-time equivalent locum tenens psychiatrists. If the caseload were evenly distributed, each psychiatrist would be assigned to approximately 63 individuals. If so, it would appear be a sufficient number of FTEs to manage the care for this number of individuals for routine assessment and medication management in collaboration with the primary care physician and PST. It would be useful, however, 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 meetings, PSP). In order to ensure the provision of services for the younger individuals at MSSLC the facility must secure the services of a board certified or board eligible child and adolescent psychiatrist. Further, due to court orders involving forensic assessment and intervention, mandated by the judicial system, a board eligible or board certified forensic child psychiatrist would be best suited to meet the needs of these individuals.	

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 interview that occurred between the director of psychology and the monitoring team discussed how the PST reached a consensus in regards to the diagnostic differential and selection of psychiatric target symptoms. Due to the turnover in psychiatric staffing and lack of integration with the PST, there was lack of a cohesive case formulation and treatment plan. The facility psychiatrists had begun to complete some comprehensive psychiatric assessments as per Appendix B. The clinical information resulting in the differential diagnosis from the assessments, quarterly evaluations, and follow-up evaluations, however, were not consistently reflected throughout the team documentation on a systemic level. Depending on what document was reviewed there were varied diagnoses listed. For example: • Individual #492 received numerous psychotropic medications. The monitoring team was concerned about inconsistent treatment plan documentation across numerous areas (e.g., diagnoses, reason for medication). The psychiatrist must collaborate with the PST to outline the diagnoses and reason for the selected medication regimen. For example: o 2/09/11 Consent form noted Depakote was for "Impulse Control Disorder, NOS; Seroquel for "Impulse Control Disorder." o 10/13/10 PSP noted Depakote ER was for seizure disorder; Seroquel for Pervasive Developmental Disorder. o 2/22/10 Neurology Consultation noted AED medications (Depakote and Lamictal) were for seizure disorder. This individual received psychotropic agents numerous years and required surgery at 22 years of age after experiencing "several days and weeks of priapism." Priapism is a persistent erection that occurs without sexual stimulation. Priapism is usually painful lasting for more than several hours. Psychotropic medications such as Trazodone cause priapism. This individual received Trazodone "for sleep" according to 1/27/11 Quarterly Psychotropic Medication Review, therefore, risk-benefit was not adequately addressed for Individual #492. Information on obtained per the POI dated 2/24/11 noted that MSSLC needed to improve in the development of psychiatric case formulations and treatment plans. Since the last review, a psychiatric assistant had been entrusted with the task of gathering information for the facility psychiatrists regarding those individuals admitted to MSSLC. Per record reviews, the psychiatric diagnosis of record was not supported by identified psychiatric symptomatology, but rather highlighted aberrant behavioral presentation of the individual. For example, Individual #109 (noted in J2 above), and Individual #159 (noted in J8 below).	Noncompliance

		There were several diagnoses that were listed for the individual that were not feasible to be utilized together. This occurred when the psychiatrist had not considered whether the symptom presentation was accounted for by another mental disorder. Impulse control disorder (ICD) and intermittent explosive disorder (IED) were frequently cited diagnoses per record review. Per DSM-IV-TR, in order to support this diagnostic spectrum, the aggressive episodes must not better accounted for by another mental disorder such as: • antisocial personality disorder; • borderline personality disorder; • a psychotic disorder; • a manic episode; • conduct disorder; • attention-deficit disorder; • not due to a general medical condition (e.g., head trauma) The following, however, were examples of multiple diagnostic spectrums given for single individuals: • Individual #197: "Anxiety; Depression; ICD; Agitation; SIB" • Individual #142: "ICD; GAD; Hallucinations" • Individual #109: "Bipolar D/O; IED; Psychosis D/O" • Individual #436: "Pica; ICD; Agitation; Pervasive Dev. D/O" • Individual #101: "ICD; Bipolar; Psychosis" Based upon the DSM-IV-TR diagnostic criteria, the monitoring team concluded that numerous individuals at MSSLC had diagnoses of an Impulse-Control Disorder, such as Intermittent Explosive Disorder, yet the PST had not adequately considered whether the symptom presentation was better accounted for by another mental disorder (e.g., manic episode, psychotic episode). Per record review, there was lack of consideration for individuals with medical conditions, such as hypoxia at birth, epilepsy, tuberous sclerosis or other genetic syndromes, or experiencing other central nervous factors resulting in psychiatric symptom presentation. For example, Individual #295 and Individual #483 (see J15 below). Individuals diagnosed as having schizophrenia as compared to individuals who are diagnosed as having a "psychotic disorder secondary to a general medical condition" should have different treatment plans. For the latter individual, further screening measures would be indicated specific for the individual's medical condition, and collaboration with other specialty consultations, such as neurology, genetics, and cardiology.	

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, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at MSSLC, only for those who did not have a current psychiatric assessment. The Reiss screen was not sufficient to replace a comprehensive psychiatric evaluation. Per an interview with the director of psychology, it was reported that the Reiss screen had been completed for all new admissions since the last review. Per record request, a list of new admissions since 1/1/10 and whether a Reiss scale was used was provided and reviewed. A facility list of individuals who received a Reiss screen illustrated that since January 2010, all 70 individuals had received a Reiss screen. Curiously, some individuals had a Reiss screen date that was earlier than their admission date. This might have been due to the Reiss being administered while they were under court ordered evaluation, prior to official admission to the facility (e.g., Individual #329, Individual #313, Individual #105). In the past six months, four individuals were referred for a psychiatric evaluation as a result of an elevated score on the Reiss screen (Individual #30, Individual #456, Individual #483, and Individual #164). This provision also required that all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis was warranted) in a clinically justifiable manner. As summarized in J2, comprehensive psychiatric evaluations were in the process of being completed, but were not yet being done, as is also required by this provision item.	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.	A review of the psychiatric and psychological documentation did not reveal case formulations that integrated the diagnostic or clinical information. This was confirmed in the meeting with the four facility psychiatrists that indicated the need to integrate pharmacological treatments with behavioral and other interventions via combined assessment and case formulation. A meeting with the director of psychology confirmed this and further highlighted the negative impact of the facility's history of inconsistent psychiatric staffing. The lack of consistent psychiatric providers and the deficiency in an integrated team case formulation resulted in varied diagnostics across disciplines. This was illustrated in the record review. The psychiatrist had not played an integral role in the multidisciplinary team approach regarding the selection of psychiatric target symptoms or identification of the behavioral presentations that may be environmentally mediated. For example: • Individual #159's PSP dated 12/20/10 noted there were numerous "problem behaviors" resulting in transfer to Austin State Hospital on 9/7/10. Several	Noncompliance

		examples provided for Individual #159 illustrated environmentally mediated incidents, yet MSSLC staff determined that Individual #159 "did not require a BSP and had "no counseling needs identified." A psychiatrist was not in attendance at the PSP meeting on 12/20/10 resulting in the absence of an integrated mulitidisciplinary team approach. Additionally, pharmacological treatments were not addressed through combined assessments (e.g., page 13 of the 12/20/10 risk versus risk of psychotropic meds: "does not receive any psychotropic medications") for this individual that was prescribed five psychotropic medications, including Haldol, Lithium, Benztropine, Celexa, and Klonopin. The last monitoring review highlighted the importance of data collection reflecting 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, starting a new job), or health-related variables (e.g., illnesses, allergies). In the observed psychiatric clinic encounters, the psychiatrist reviewed the medical record. Of concern, however, was that one of the facility psychiatrists informed the monitoring team that he had reviewed data sent via computer, yet this information was not formally entered into the individual's record. Lack of shared information contributed to outdated data affecting diagnostics and, thus, impaired the PST's decision-making capacity. Examples were identified in the observed psychiatric clinics that reflected problems with the lack of identification of psychiatric target symptoms associated with the Axis I diagnosis. To further complicate matters, depending on what document was reviewed, there were numerous psychiatric diagnoses listed as current. In regard to selection of the psychotropic medication there was a lack of documented rationale for a particular regimen. The psychology representative presented target behavior data that were not associated with an indication for pharmacological intervention, yet this was the pervasive basis utilized by the psychiatrist to change the medication regimen. Psychology and psychiatry need to formulate diagnoses and treatment plans as a team. Regarding review of medications prescribed for individuals at MSSLC, several records revealed medication indication was "mood stabilization" when the individual did not have an Axis I mood disorder diagnosis; additional records reviewed noted medication indication was for "anxiety" when the individual did not an Axis I anxiety diagnosis. In the records reviewed, there was insufficient information noted in the psychiatric documentation to arrive at a DSM-IV-TR diagnosis, including when a change in diagnosis occurred, deficiency in notation of a pertinent differential diagnostic formulation, and	

		lack of documentation regarding related medication target symptoms to determine medication efficacy. The lack of consistent psychiatric providers and the deficiency in an integrated team case formulation resulted in varied diagnostics across disciplines. In order for the facility to address polypharmacy (i.e. reduce medication burden), one needs to determine the actual target symptoms of the medication (e.g., seizure disorder, major mental illness, or both) and then make the determination if treatment with a medication is warranted. • The case of Individual #226 illustrated that MSSLC utilized psychotropic medication in the absence of a psychiatric diagnosis. Upon review of the PSP dated 2/11/11, it was noted that Individual #226 did not exhibit any behaviors that required a formal Behavioral Support Plan (BSP) or psychiatric services and, further, that this individual did not receive psychoactive medications. There was no Axis I diagnosis, yet this individual received Lorazepam (Ativan), an anti-anxiety medication for agitation. Agitation is not a DSM-IV-TR diagnosis. To further complicate matters, this individual had intractable epilepsy and was prescribed another medication similar to Lorazepam (Valium). • Individual #492 received numerous psychotropic medications. The psychiatrist must collaborate with the PST to outline the diagnoses and reason for the selected medication regimen. For example: o 2/09/11 Consent form noted Depakote was for Impulse Control Disorder, NOS; Seroquel for Impulse Control Disorder. The 10/13/10 PSP, however, noted that Depakote ER was for seizure disorder, and Seroquel was for Pervasive Developmental Disorder. • Individual #483 received numerous psychotropic medications. The psychiatric target symptoms of each psychotropic medication were not outlined for this individual who had a complex neuro-diagnostic presentation.	
J9	Commencing within six months of the Effective Date hereof and with 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	Observation of the Behavior Therapy Committee (BTC) meeting, interviews with the four facility psychiatrists, and interview with the director of psychology confirmed that the psychiatrists were not consistent active participants in the PSP process. As noted above, there was little relevant participation by the psychiatrist's at BTC. Note that BTC is only one forum for possible psychiatry participation in the PSP process. There are numerous other venues for this to occur, such as PSP annual meetings, PSPA meetings, and via other, perhaps more informal interactions. During the observation of the Behavior Therapy Committee, PBSP documents were reviewed for Individual #268, Individual #539, Individual #159, Individual #431, and Individual #161. • Individual #539 was a minor diagnosed with Conduct Disorder who received an atypical antipsychotic medication, Zyprexa. His PSP dated 1/11/11 noted target	Noncompliance

	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.	behaviors of inappropriate sexual behavior, instigating peers, and refusing to follow directions. The psychiatrist's signature was not listed on PSP. The HRC review of the BSP dated 1/11/11 listed another individual's name in the risk versus risk analysis section. Antipsychotic medication prescribed for any individual, particularly youth, may result in potential side effects that may be life threatening (e.g., neuroleptic malignant syndrome) or irreversible (e.g., Tardive Dyskinesia) and warrant a detailed review. It was unacceptable for the plan approval of such a restrictive intervention to list another individual's name instead of Individual #539. The facility psychiatrists acknowledged that in many cases, the behavioral intervention, behaviors being monitored and tracked, and the behaviors listed in the positive behavioral supports were not relevant to the psychiatric diagnoses and did not facilitate determination of efficacy of psychotropic medications. Implementation of elements as required by this provision item, whereby the PST, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, have not been met.	
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.	An individualized risk-benefit analysis regarding the utilization of psychotropic medication in individuals with developmental disabilities was not reflected in the records reviewed. Further, any documented risks of receiving/not receiving medication and expected benefits/risks were not specific to the individual. The same insufficient documentation was cited repetitively throughout numerous records. During the four psychiatric clinic observations conducted during this monitoring review, the nurse case manager was present. Discussion of the risks/benefits of the individual's psychotropic medication was not observed in any of these clinics. When the monitoring team inquired if the risk-benefit analysis was going to be discussed, the psychologist stated that this appointment was "only a follow-up" not a "quarterly" and, therefore, the team did not plan to review the medical data of Individual #420. The monitoring team was surprised to hear about different types of psychiatry clinic. Typically, there are standard components to any psychiatry clinic, and risk/benefit discussion is one, especially if there is no documentation in the individual's record that this discussion has occurred. The PST, however, ultimately discussed the elements that constituted a risk-benefit analysis because of inquiry by the monitoring team. During this discussion, the team discovered the individual had experienced an adverse drug reaction. The PST determined that the content of the information derived from the medical discussion justified completion of an adverse drug reaction form. The nurse and psychiatrist were receptive to the feedback from the monitoring team, however, this was not the case for	Noncompliance

		all PST members. Other difficulties noted with this particular individual's review included vague, undefined target symptoms that were not relevant to the diagnosis. This identification of either irrelevant or unassociated target symptoms was pervasive in the records reviewed. Target symptoms must be individually derived, associated with the individual's diagnosis, and must be monitored in order to provide the prescribing practitioner with information upon which to base pharmacological decisions.	
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 Acting Director of Pharmacy was in the position since February 2011. Per an interview with the Acting Director of Pharmacy, the facility-level review system to monitor, at least monthly, intra-class and inter-class polypharmacy at MSSLC had been revised since the last review. Psychiatry services policies and procedures manual, Medical-17, dated 11/1/10 outlined the section entitled polypharmacy as follows: • "MSSLC must establish a system to review and monitor individuals that are prescribed two or more psychoactive/psychotropic medications from the same class, or three or more psychoactive/psychotropic medications, regardless of the class. The monitoring system must provide information to the facility's Pharmacy and Therapeutics Committee that allows tracking and trending of prescribing information by individual, by prescriber, and by medication." There was progress made in the pharmacy department beginning with the implementation of establishing a system to review and monitor individuals receiving polypharmacy. Per the facility POI self-assessment: • "the monthly polypharmacy data was submitted to the Medical Director and analyzed and verified by one of the psychiatrist to arrive at the final polypharmacy data to be submitted to the State Office. These numbers including intra-class polypharmacy served as the basis for the agenda of the monthly Polypharmacy Committee meeting…The psychiatrists were encouraged to document in their IPNs the justification and other pertinent information regarding the polypharmacy that discussed at the monthly polypharmacy meeting… Polypharmacy is also being reviewed at the Quarterly Drug Regimen Review by the Clinical Pharmacist and recommendations are submitted to the psychiatrist." The pharmacy department under the leadership of the acting pharmacy director had provided pertinent information to the facility psychiatrists as outlined in the POI. The next step involves the psychiatrists learning the cases assigned to them to address these findings (also see section N).	Noncompliance

		Facility-wide data regarding polypharmacy, revealed that 71 individuals' medication regimen met criteria for polypharmacy. This document, however, was not dated. During the prior facility monitoring review, information submitted by the pharmacy regarding this provision was incorrect due to a prior pharmacist utilizing an incorrect definition of polypharmacy in determining what individual's medication regimen met criteria for this classification. This was corrected in the intervening period per interviews with the current pharmacy department staff. In typical institutionalized populations, where 30% to 40% of individuals have epilepsy and as many as 70% may have some other medical condition of significance, drug interactions become an increasingly important consideration" (see Kaplan and Sadock's Comprehensive Textbook of Psychiatry, Ninth (9th) Edition Volume II, Chapter 37 Intellectual Disability, 2009). The pervasive practice pattern at MSSLC was utilization of psychotropic medication inclusive of polypharmacy for behavioral control. Targeting maladaptive behaviors (e.g., aggression and self-injurious behavior) resulted in what appeared to be the over-prescription of psychotropic medication, representing a substantial departure from generally accepted professional standards of care. Due to recent implementation of tracking psychotropic medication, data were not finalized nor dated at the time of this onsite review. For example of the 71 individuals prescribed psychotropic polypharmacy per facility-wide polypharmacy data, there were four prescribed "strictly intraclass polypharmacy." This was not consistent with the list provided to the monitoring team by the psychiatric assistant that listed 21 individuals prescribed intraclass polypharmacy. Further, polypharmacy data were not yet consistently completed or available for review. The facility reported that the reviews of data from November 2010 through January 2011 were not finalized at the time of this onsite review. The elements of the provision have not been met since last review. In order to ensure that the use of psychotropic medications was clinically justified, and that medications that were not clinically justified were eliminated (or were in a plan for elimination), it was imperative for the psychiatrist, psychologist, primary care physician, nurse, the interdisciplinary team, and other experts as deemed necessary (i.e., neurologist) to have identified DSM-IV-TR diagnosis and target symptoms associated with such diagnosis. In order for the facility to address polypharmacy (i.e., reduce medication burden) one needs to determine the actual target symptoms of the medication (e.g., seizure disorder, major mental illness, or both) and then make the determination if treatment with a medication is warranted.	

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.	There were 18 individuals diagnosed with tardive dyskinesia (TD). The diagnosis of TD, however, was not reflected in the Axis I diagnoses listed in the spreadsheet of individuals prescribed psychotropic medication. There was lack of documentation for diagnostic consistency of TD per record review. The following individuals were diagnosed with TD and enrolled in psychiatry clinic: Individual #521, Individual #248, Individual #462, Individual #518, Individual #239, and Individual #216. Individual #462: • MAR 2/1/11-3/1/11: Diagnosis of Tardive Dyskinesia was not in the diagnoses section on the MAR, yet "Antisocial Personality Disorder" was listed. This individual was prescribed an antipsychotic agent (Quetiapine) and an AED. • Nursing Assessment form did not have a check box for the category of abnormal motor movements, such as in the neurology or psychiatry sections for Tardive Dyskinesia. • "Neuroleptic Induced Tardive Dyskinesia" was on his current active medical diagnoses dated 8/4/10 in nursing assessment. • 12/16/10: Psychiatrist noted this individual had not been examined by psychiatry since 6/24/10 due to multiple refusals and "scheduling issues." Psychiatrist noted there were no psychomotor abnormalities and "no TD or dyskinetic movements noted though reported in past hx." • Psychiatrist did not list TD as a diagnosis and did not recommend removing the diagnosis of TD. The psychiatrist did not document the DISCUS or MOSES results. • 3/25/10: DISCUS was 0 with conclusion "No TD." • 4/06/10: Physician's Annual Medical Review noted Neuroleptic Induced Tardive Dyskinesia by history-onset date unknown. • 8/18/10: DISCUS administered by a different staff noted "Tardive Dyskinesia" in one section. The DISCUS score was 1; conclusion selected was "No TD." To summarize, Individual #462 was noted to have Tardive Dyskinesia in a list provided to the monitoring team. This established diagnosis for Individual #462, however, was not consistently agreed upon as outlined in the case summary. This individual was enrolled in the psychiatry clinic and received psychotropic medication inclusive of Quetiapine and Valproic Acid. Certain medications (e.g. Quetiapine) can suppress the symptoms of TD and, therefore, can result in a lowered DISCUS score. This does not equate with the individual no longer having Tardive Dyskinesia. The psychiatrist, physician, or other specialist, such as a neurologist, must evaluate each individual receiving psychotropic medication and apply all relevant clinical information for the determination of accurate diagnostics, intervention, and monitoring of side effects.	Noncompliance

		Tardive Dyskinesia, a movement disorder characterized by frequent, repetitive, involuntary movements of the lip, tongue, jaw, face, trunk, and/or limbs is one of the most notorious side effects of antipsychotic medications. Additionally, medication utilized to target the gastrointestinal system, such as Metoclopramide poses an increased risk for development of movement disorders. Although medications such as antipsychotics and Metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements, such that the reduction or absence of the medication that occurred during a taper or discontinuation would result in increased restlessness and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as bipolar disorder. Therefore all diagnoses inclusive of TD must be routinely reviewed and documented. There may be various symptoms of TD inclusive of, but not limited to, akathisia, choreoathetosis, tics, and blepharospasms. Individuals experiencing akathisia whether secondary to a medication increase, due to tardive akathisia, or secondary to an individual refusing and not receiving his or her medication. In some cases, these individuals have been known to exhibit aggressive behavior as they have a subjective sense of psychomotor restlessness and experience abnormal involuntary motor movements that would not be halted with behavioral interventions. Psychiatry Services policies and procedures manual, Medical-17, dated 11/01/10 outlined the section "monitoring for medication side effects." Per MSSLC policy, the monitoring of side effects scale (MOSES) and the dyskinesia identification system: condensed user scale (DISCUS) must be completed for each individual receiving psychotropic medication." It was noted that the MOSES must be completed at least every six months and the DISCUS must be completed at least every three months. The procedure regarding the staff responsible for administering these scales was addressed in an earlier section of the policy "MSSLC Assurances" clinical services as follows: "prior to prescribing psychoactive and psychotropic medications known to cause movement disorders, a trained and competent staff member must screen the individual for abnormal involuntary movements using the…(MOSES) and (DISCUS), and document the result of the examination." The document did not specify how it was determined if the staff member administering the scales met the competency criteria. The policy outlined that the psychiatrist must review the results of these scales to monitor the side effects of "anticonvulsant and psychotropic medications." It did not specify if this was pertaining to the prescription of all anticonvulsants facility-wide or only for those individuals receiving anticonvulsants prescribed in order to target	

		psychiatric symptoms associated with an Axis I diagnosis, or for those individuals with neuropsychiatric conditions, such as individuals with both a seizure disorder and a mental health diagnosis. Further, policy documentation addressed that individuals prescribed metoclopramide would have the "same MOSES and DISCUS monitoring as those receiving psychotropic medications." The policy did not specify the procedure regarding the staff responsible for administering these scales or what physician was responsible for the review of the scales regarding individuals receiving Metoclopramide. The policy addressed the diagnosis of dyskinesia within the MSSLC Assurances section and included the requirement that a "psychiatrist, neurologist, or PCP must verify the diagnosis of dyskinesia, including tardive dyskinesia." According to policy, the diagnosis must be documented in the individual's record to include suspected or known duration and severity. The policy also required education about the diagnosis and its implications for psychoactive and psychotropic medication for the individual and the LAR. The policy indicated that the "prescribing provider must assess the risks and benefits of continued psychoactive and psychotropic medication use and communicate these to the individual and the LAR." In regard to further intervention, it was noted that "the prescribing professional must obtain and document consultation from a psychiatrist or neurologist if continued use of psychoactive or psychotropic medication is considered after the diagnosis of tardive dyskinesia" was verified. Concerns regarding the facility's implementation of the requirements of this provision item included several questions: • How was inter-rater reliability ensured? • How were staff trained who completed the MOSES and DISCUS? • How was competence assessed for those administering the scales?	
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	This provision summarized expectations to be met and delivered by psychiatry in regard to every individual receiving psychotropic medication. The delivery of care was to be outlined as part of the documented services designed for the individual per the personal support plan (PSP): 1. To ensure that the treatment plan for the psychotropic medication identified a clinically justifiable diagnosis or a specific behavioral-pharmacologic hypothesis. • This required validity of the diagnosis supported by psychiatric symptomatology and/or behaviors that resulted in the selected psychiatric diagnosis. 2. Expected timeline for the therapeutic effects of the medication to occur. • The standard of care requires the implementation of evidence-based psychiatry that involves review of research evidence to be applied in	Noncompliance

for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral 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.

concert with the clinical expertise with consideration for the values of the individual for selection of the treatment regimen.

3. Objective psychiatric symptoms or behavioral characteristics monitored to assess the treatment's efficacy, specifically by whom, when, and how this monitoring will occur.
    - Components of evidence-based psychiatric practice include identification of treatment goals, measures, and methods utilized inclusive of time frame for improvement.
4. 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.

Records were reviewed for individuals listed in the document request, including but not limited to the last 10 newly prescribed psychotropic medications. The monitoring team was provided with "treatment review/progress noted documenting the rationale" for the choice of medication prescribed.

One medication change at a time should be recommended unless otherwise medically indicated (e.g., because of a discovered side effect, adverse drug reaction) in order to allow monitoring for efficacy of the treatment regimen via data collection of the psychiatric target symptoms. There should be an adequate time period allowed for the medication to reach a steady state, monitor vital signs, weight, medication levels and laboratory data, and to assess whether the individual tolerated the change in medication. This practice pattern was not found at MSSLC. The following two cases are illustrative of practice at MSSLC.

Case #	Psychiatric symptom/behavioral target symptoms	Diagnosis	Plan and date of consult
Individual #386	2/3/11: Progress note: Aggression "way out of control; MSE quiet…tearful, guarded, mildly depressed"	2/3/11: Progress note: ODD. 6/8/10: BSP: ODD; ADHD (combined type); R/O Physical, Sexual and Emotional Abuse of a Child (Victim)	2/3/11: Orders: Discontinue Depakote and Trazodone; Zyprexa for ODD
Individual #268	2/3/11: Progress note: "Still getting in fights…said [you're	2/3/11: Progress note: MDD and Conduct Disorder.	1/13/11: Add Diagnosis: Major Depression (MD).

			going to have to restrain me]…still appears depressed… D/C Depakote-"no help"…Add Abilify for conduct disorder (will also augment paxil for dep.) RTC one month.	6/8/10: BSP: Cannabis Abuse; Alcohol Abuse; Sedative, Hypnotic or Anxiolytic Abuse; Conduct Disorder, Severe, Childhood Onset	Start Depakote ER for Conduct Disorder; Paxil for MD. 2/3/11: Orders: Discontinue Depakote ER; Abilify for conduct disorder. 2/17/11: D/C Abilify; Start Zyprexa for conduct disorder	

In the above examples, due to the range of diagnoses complicated by oppositional and aggressive behaviors, comorbid disorders should be the primary indication for psychotropic medication. Medications for individuals exhibiting acute or chronic aggression are a controversial intervention for individuals with developmental disability. Medication efficacy may be different for those individuals with predatory aggression versus aggressive symptomatology associated with a dysphoric presentation or in combination with disruptive behaviors.

In the above examples, multiple medication changes were made concurrently. This made it impossible for the prescribing psychiatrist to determine what medication, if any, had a positive or negative response with respect to the individual's symptoms. In addition, the individual's diagnoses were changed with no supporting documentation of a case formulation or justification for a particular diagnosis.

Per record reviews, the facility psychiatrists were participating in some of the PSP activities. The documentation of the case formulation, diagnostic impression, and psychiatric treatment planning frequently varied across disciplines in records reviewed. The information including, but not limited to, the case formulation and approach to applied treatment were not reflective of evidence-based practice and, thus, insufficient to meet the requirements of this provision item.

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	Per the facility POI self-assessment dated 2/24/11, the consent policy was in the process of revision. Per the director of psychology, the psychology staff had been responsible for the coordination of consent for psychotropic medication "by default" due to difficulty with the hiring and retention of psychiatry staff. The informed consent process at the facility was not consistent with the generally accepted professional standard of care. Numerous examples of consent forms utilized were 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 basic description of the benefits of the medications. There were no listings of alternatives to treatment or what would/could occur if consent were not given. The	Noncompliance

	consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	facility director, 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. For example, consents in the record of Individual #197 were not in keeping with generally accepted professional standard of care. A consent form for Seroquel dated 9/21/10 documented incomplete risks for treatment with this medication. Many side effects, including weight gain, metabolic syndrome, and Neuroleptic Malignant Syndrome were not included. A consent form in the record of Individual #431 included information for three different psychotropic medications on one form. Side effects, including liver abnormalities, were not included with regard to Depakote ER. Side effects, including movement disorders and neuroleptic malignant syndrome, were not included for antipsychotic medications, such as Seroquel XR. The consents reviewed rarely included relevant psychiatric target symptoms associated with a DSM-IV-TR diagnosis. Per record review and interview with the facility psychiatrist, it was noted that Individual #197 was prescribed antipsychotic medication and had unilateral gynecomastia (enlarged breast). The 1/10/11 MOSES was completed for individual #197 and revealed the following: mild drooling/pooling, moderate breast swelling, incontinence, moderate agitation, moderate irritability, and "risk of akathisia." On 3/14/11, Individual #197 was not brought to the scheduled psychiatry clinic. • A short period after the monitoring team met with the facility psychiatrist, the nurse case manager located Individual #197 and personally escorted him to the facility psychiatrist. The individual slept throughout the entire interview and was nonverbal. He was receiving numerous sedating psychotropic medications reflective of intra-class and inter-class polypharmacy inclusive of Quetiapine, Clonazepam, and Lorazepam. • Diagnostics were not consistent in documentation provided, per the psychiatrist, or across disciplines. The facility psychiatrist noted "Cerebral palsy, spastic quadriplegia, anxiety, depression [secondary] to neurologic illness" in the integrated progress note. HRC review on 1/4/11, noted "Impulse Control Disorder NOS…Ativan has been added to his psychotropic regimen…Risk versus Risk Analysis: The risk of not taking the medication is that he will continue to exhibit symptoms of his mental illness and not benefit from the opportunities and activities offered…The risk of taking the medication is that he may exhibit possible side effects of the medication." Per record review, there were no noted drug-drug interactions for individual #197 who was now receiving two benzodiazepine medications in combination with another sedating psychotropic medication, Quetiapine. The sedating polypharmacy regimen placed individual #197 at risk for aspiration and respiratory depression superimposed on the compromised medical condition of cerebral palsy with requirement of enteral	

		feedings, and was nonverbal therefore not able to express other side effects experienced. Generally accepted professional standards of care require that the prescribing practitioner disclose to the individual the risks, benefits, side effects, alternatives to treatment, and 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 then be documented in the individual's record. Given the importance of informed consent, the development of an updated facility policy and procedure regarding this topic is warranted. In interviews with facility psychiatry staff and the psychiatric assistant, there were various answers given to the monitoring team with regard to determining the legal status of a particular individual. For example, "the facility director signs all the consents" and "medical records would know who to call for consent." When the monitoring team asked the facility psychiatrist to locate the LAR for an individual in the record, it was apparent that this information was not readily available because the psychiatrist was not able to identify status upon reviewing the record. Additionally, the psychiatrist was not able to identify the primary care physician responsible for the individuals care, "I don't know which one it is…it is an assumption." Collaboration and consistency between the psychiatrist and the PCP were critical in making decisions together that resulted in the proposal of care presented to the LAR. Knowledge of guardianship status for of an individual for the purpose of consent was mandatory for the implementation of services and therefore should be easily accessible, regularly updated, and placed in a designated section of the record. Ultimately, via an onsite document request, the monitoring team was provided information that included the individual's name, home, age, psychiatrist, and legal status. It would be beneficial for the facility to maintain this list and give it to the providers for their reference. As noted in the past review, in an effort to address problems in the facility's informed consent practices, it was recommended that the facility consult with the state office that, 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.	
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	Per interview with the facility medical director, MSSLC had been attempting to obtain neurology consultative services via a monthly scan call with another medical facility. MSSLC did not have onsite neurology consultation at the time of this monitoring visit. There were no neurologists on the medical staff at MSSLC. Due to the lack of available neurology consultation, there was no coordination with regard to the prescription of	Noncompliance

	coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	medications to treat both seizures and a mental health disorder. Neurology consultation had been provided at Scott & White located approximately two hours from MSSLC. These consultations were requested per the primary care physician. Documentation of seven individuals requiring emergency room visits due to seizure activity occurred between the months of October 2010 and February 2011. Of these seven individuals, most concerning was Individual #295, who visited the emergency room five times. When this individual received neurology consultation on 10/11/10, a vagal nerve stimulator replacement was performed. This individual was reportedly "sent to the ER due to seizure activity" 10/2/10, 10/9/10, 11/6/10, 1/16/11, and 1/25/11. More details are provided below. Individual #295: • This individual had a diagnosis of "Psychosis, NOS" and "Adjustment D/O with depressed mood" noted 12/29/10 on the form "Psychology Note Quarterly Medication Review Update." Medication prescribed for Axis I included Risperdal and Celexa. There was not a complete list of medications outlined in this medication review update. No changes in medication were recommended. • There was no documentation in section "Significant Events/Symptoms this Quarter." This section of the QMR was supposed to address significant problems or progress to indicate the need to consider changes in medication. • 12/23/10 Quarterly Psychotropic Medication Review outlined that Individual #295 was also receiving Dilantin, Lamictal, Lyrica, Valium, and Vimpat for Seizure Disorder. The justification for polypharmacy was "necessary to prevent relapse and maintain stability." As captured in the example of Individual #295, an individual who had required numerous emergency evaluations for seizure activity, was assigned a psychotic psychiatric diagnosis, and was administered an extensive polypharmacy regimen, it was apparent that the integrated system of care and review was not implemented. The neurologist and psychiatrist had not collaboratively determined what medication regimen was appropriate. Drug-drug interactions can occur with agents prescribed by the psychiatrist affecting drug levels of AEDs and antipsychotics can lower the seizure threshold resulting in more seizure activity. The common comorbidity of physical illness, such as epilepsy in individuals with intellectual disability may increase the risk of the individual experiencing psychiatric symptoms secondary to a general medical condition. Continuity of care between the psychiatrist and neurologist was warranted for the selection of the medication regimen in order to make thoughtful adjustments to the individual's medication regimen, to educate the PST on pertinent target symptoms to track with the alteration in regimen, to	

		routinely monitor potential side effects, drug-drug interactions, medication levels, laboratory results, vital signs, and other pertinent medical data as clinically indicated. There were a total of 105 individuals treated with Anti Epileptic Drugs (AEDs). Of these individuals, 40% (42) were prescribed older AEDs, such as Phenobarbital, Dilantin, and/or Mysoline. It was initially difficult to determine how many individuals at MSSLC had a diagnosis of seizure disorder and were prescribed AEDs to treat both seizures and a mental health disorder. A record request for a spreadsheet of individuals (listed alphabetically) prescribed psychotropic/psychiatric medication, listing name of individual, residence/home, psychiatric diagnoses inclusive of Axis I, Axis II, and Axis III, and medication regimen (including psychotropics, nonpsychotropics, and PRNs including dosage of each medication and times of administration) was provided, but was incomplete because Axis III diagnoses were not included. Axis III would be the heading under which a diagnosis of seizure disorder would be noted. During the monitoring review, a second document, specifically a list of individuals prescribed AEDs and psychotropics, was requested. Per this document, there were 55 individuals determined to require neuropsychiatric collaboration. These individuals reportedly had both a seizure diagnosis and a mental health diagnosis. As there were 251 individuals enrolled in psychiatry clinic as of 3/16/11, 22% of these individuals appeared to have been prescribed AEDs and psychotropics. The indication for the specific medication was not listed on this document, therefore, the monitoring team was not able to determine if AEDs were prescribed to treat both seizures and a mental health disorder, or if they were prescribed for an isolated indication. The need for improved collaboration was also illustrated in the case of Individual #483 as follows: • At age six years, he started having "small seizures," loss of language and writing, stared into space with lack of attention even for activities he enjoyed, and became sleepy or hungry. • His PSP dated 3/29/10 noted that Individual #483 was a new admission to MSSLC. There was not a psychiatrist in attendance according to the signature sheet listing personal support team participants. Axis I Diagnoses included Impulse Control Disorder NOS, Autistic Disorder, Obsessive Compulsive Disorder, and Insomnia (by history). Psychoactive medications included Risperidone, Clonazepam, Naltrexone, Clomipramine, Carbamazepine, and Topiramate. "This risk of not receiving these medications…include but are not limited to an increase in his maladaptive behaviors and psychiatric symptoms… greater than any side effects of these medications."	

		• In a 3/3/11 Nursing entry Quarterly Psych Med Review, it noted, "No psychologist available. Psychiatry, QMRP, and nursing present, reschedule."5/12/10: Neurology consultation per Scott & White staff recommended continued use of Carbamazepine and Topiramate at current doses for this individual with risk of seizures. EEG showed bilateral cortical dysfunction and he had a history of an abnormal EEG in 2009. Recommendations included consider head CT to rule out intracranial pathology. RTC one year. There was no documentation of further seizure events since admitted to MSSLC. • 2/18/11: PCP ordered 24 hour EEG to rule out temporal lobe seizures. PCP documented records from previous facility did not indicate that Individual #483 had a 24 hour EEG. CT of head 6/10 was negative for mass effect. • PSP Addendums provided to the monitoring team included the following: There was not a psychiatrist in attendance according to the signature sheet of personal support team participants for the following meetings: 1/11/11, 12/17/10, 12/3/10, 12/10/10, 12/2/10, 11/22/10, and 11/12/10. o The psychiatrist attended the meetings for 12/29/10 and 11/12/10. Subspecialty consultation between the psychiatrist, neurologist, PCP, and geneticist were critical in the above case in order to establish a relevant differential diagnoses and rule out organic contributants to presenting symptoms. For example, Individual #483 experienced seizure activity, a loss of speech and a regression in skills at a young age of six years. The medical treatment team must confer on this and other difficult cases in order to determine the presence or absence of specific syndromes that may be the etiology of this and other individual's medical and behavioral challenges (e.g., Landau-Kleffner syndrome). The psychiatric diagnostic spectrum listed in the record of this individual did not highlight the relevant clinical presentation and did not list any possible disorder that might be secondary to a medical condition. Additionally, it was unacceptable practice to not appropriately identify the psychiatric target symptoms of each psychotropic medication as opposed to noting a generic risk versus benefit analysis for this individual with a complex neuro-diagnostic presentation, loss of functioning at a young age, and continued risk variables (e.g., self injurious behavior, aggression). Consistent with past recommendations by the monitoring team, 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 consultation and the recommended follow-up. This would include the number of individuals requiring neurological consultation who were not also prescribed psychotropic medication. The facility must consider options for improving neurologic consultation availability. This could include exploring	

		consultation with local medical schools and clinics, and considering telemedicine consultation with providers currently contracted in other DADS facilities.	

Recommendations:

1. Recruit a child and adolescent psychiatrist preferably with specialty in forensic psychiatry to manage the psychiatric care for those individuals less than 18 years of age.

2. The medical director should determine the assignment of cases depending on the psychiatrist's experience. In order to learn more about the work experience of the current four facility psychiatrists, encourage the psychiatrists to update their curriculum vitae to include experience (including timeframe and setting) in working with individuals with developmental disabilities, board certification or board eligibility, list of ACGME programs completed and specific dates of attendance, and identified expertise in all specialties such as Forensic Psychiatry, and Child and Adolescent Psychiatry. The psychiatrist should also note if they have ever been deemed an expert for court testimony in the State of Texas, specifically citing the District, reason, and date of such testimony.

3. Integrate the prescribing psychiatrist into the overall treatment program at the facility as follows:
    a) In discussions regarding treatment planning and behavioral support planning;
    b) Utilize the psychiatric treatment plan for psychotropic medications written per the psychiatrist in the overall team treatment plan;
    c) Ensure the individual's psychiatric diagnosis is consistent across disciplines;
    d) Involve psychiatrists in decisions to utilize emergency psychotropic medications;
    e) Psychiatry and psychology to form collaborative case conceptualizations;
    f) Psychiatry and psychology to jointly determine psychiatric target symptoms to be monitored;
    g) Psychiatry should be consulted regarding non- pharmacological interventions.

4. Individualize the desensitization plans for dental and medical clinic. Implement cross-discipline consultation regarding pretreatment sedation options.

5. Ensure that the target symptoms/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication were appropriate
    - If DSM-IV-TR diagnosis was met, utilizing medication that has validated efficacy as supported by evidence-based practice, was the appropriate course of intervention in concert with behavioral intervention.
    - 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. These data must be presented in a manner that is useful to the physician, that is, in graph form, with medication adjustments, identified antecedents, and specific stressors identified.
    - For each individual, this information must be reflected in the case formulation and psychopharmacological treatment plan with illustration of collaboration with the PST. The team integration should be measured via consistency in the records across disciplines.

6. Any change in diagnostics should summarize the symptoms and criteria met according to DSM-IV-TR to justify the diagnosis.

7. Regarding the addition of a medication or a medication dosage change, documentation outlining psychiatric target symptoms for each psychotropic medication prescribed and the potential difficulties that may occur with the change in regimen is required. As noted per past review, data should include 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 variable (e.g., illnesses, allergies).

8. Draft and implement policy and procedure governing the details of the referral process of individuals requested to be enrolled in the psychiatric clinic at MSSLC inclusive of issues the PST must address for the psychiatric consultation as follows:
    a) IDT to rule out medical etiology of presenting symptomatology instead of immediate referral to psychiatry;
    b) responsibility and detailed function of the psychiatric assistant particularly involving coordination among disciplines for efficient scheduling, securing consistent and appropriate meeting room to accommodate the needs of the individual and provide adequate workspace in clinic setting;
    c) responsibility and detailed function of the designated staff to ensure that the individual was present for the scheduled appointment, and what occurs if the individual was not present for the evaluation;
    d) responsibility and detailed function of the psychiatrist including the role of integrating information with the IDT and documentation in PSP; review of scales, consults, documents, labs, medical monitoring; and involvement with PCP, medical, and dental, regarding pretreatment sedation; documentation of the rationale for the prescription of specific medications and potential side effects and drug interactions particularly addressing concerns when polypharmacy was implemented;
    e) responsibility and detailed function of the nurse such as implementing and providing reports for the DISCUS and MOSES screens so that they are performed and reviewed within the appropriate time frame; improve coordination between psychiatry and nursing, specifically with regard to documentation of laboratory examinations and other clinical information necessary for the psychiatrist during psychiatry clinic.
    f) responsibility and detailed function of the psychologist including presenting data relevant to the monitoring of psychiatric symptoms supportive of the established DSM-IV-TR diagnosis.

9. Complete the comprehensive psychiatric evaluations following the requirements of the Settlement Agreement Appendix B.

10. Continue to utilize the Reiss screen for new admissions as well as those individuals who do not have a current psychiatric evaluation, or who are not enrolled in psychiatry. Determine the mechanism for referral for psychiatric evaluation following a positive Reiss Screen.

11. In an effort to address the deficit regarding informed consent practices, it was recommended that the facility consult with the state office that, in turn, may want to consider a statewide policy and procedure outlining how to obtain appropriate informed consent that comply with Texas state law and generally accepted medical practice.

12. Formalization of the PSP process to include review of the risk/benefit ratios for the prescription of psychotropic medications that are authored either by psychiatry or at a minimum in collaboration with psychiatry. Individualize the risk versus benefit for each psychotropic medication prescribed. For example, if an individual has Diabetes Mellitus, and is prescribed a medication that exacerbated Diabetes (e.g., Zyprexa, an atypical antipsychotic), then outline justification.

13. The psychiatrist should utilize the findings obtained via the polypharmacy review committee as it relates specifically to the medication regimen prescribed for each individual and for the review of the prescribing psychiatrist's practice pattern regarding polypharmacy. Continue efforts to

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.

14. The pharmacy should ensure dates are recorded on all documents such as the "list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date" and the facility-wide data regarding polypharmacy.

15. Consistent with past review recommendations, 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 consultation and ongoing neurology services, including those individuals not prescribed concomitant psychotropic medication. The facility must consider options for improving neurologic consultation availability. This may include exploring consultation with local medical schools and clinics and considering telemedicine consultation with providers currently contracted in other DADS facilities.

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 #591 (1/4/11), Individual #491 (1/11/11), Individual #398 (9/27/10), Individual #142 (2/23/11), Individual #113 (1/26/11), Individual #589 (11/30/11), Individual #492 (1/28/11), Individual #82 (12/8/10), Individual #508 (2/21/11), Individual #519 (11/1/10), Individual #441 (1/20/11), Individual #21 (1/20/11), Individual #235 (2/24/11), Individual #303 (3/3/11), Individual #146 (2/22/11), Individual #568 (3/11/11), Individual #431(2/16/11), Individual #159 (3/15/11), Individual #161 (2/15/11), Individual #367(1/12/11), Individual #514 (8/10/10), Individual #6 (4/23/10), Individual #365 (3/19/10), Individual #177 (3/30/10) o Positive Behavior Support Progress notes for: • Individual #398, Individual #519, Individual #491, Individual #591, Individual #161 o Functional Assessments for: • Individual #591 (2/28/11), Individual #398 (9/27/10), Individual #519 (10/1/10), Individual #491 (1/23/11), Individual #183 (10/01/10), Individual #441 (11/15/10), Individual #21 (1/24/11), Individual #142 (2/22/11) o Initial psychological assessments for: • Individual #136, Individual #471, Individual #349, Individual #31, Individual #164, Individual #273, Individual #252, Individual #241, Individual #294, Individual #367 o Psychology Peer Review Committee Policy, dated 3/7/11 o Census Counts by Home, dated 3/13/11 o Spreadsheet containing dates of psychological assessments, undated o Peer Review minutes, dated 11/1/10, 11/8/10, 11/15/10, 11/22/10, 11/29/10, 12/15/10, 12/29/10, 1/5/11, 1/12/11, 2/02/11, 2/9/11, 2/16/11 o A spreadsheet of all Psychology Department Staff (dated 2/11) o A spreadsheet of each psychologist's degree, licenses, certifications and BCBA coursework completed (undated) o A list of all individuals receiving counseling/psychotherapy, undated <u>Interviews and Meetings Held</u>: o Charlotte Kimmel, Ph.D., Director of Psychology o Lupita Alfano, Psychology Assistant o Steven Parkhurst, Psychologist o Michael Miller, Psychologist o Molly Chase, Psychologist o Psychology Department staff

	Observations Conducted: o Peer council, WR 4 o Psychiatry Clinic • Staff Present: - Dr. Coppedge, Psychiatrist; Steve Hurst, QMRP; Michael Miller, Psychologist; Terri Moon, QA auditor; Sandra Hathcher, RN, Michelle Boutte, Psychiatrist Assistant • Individual Presented: - Individual #24 o Psychiatry Clinic • Staff Present: - Dr. Brown, Psychiatrist; Lisa Brown, RN; Paulette Linton, QMRP; Michele Chandler, Psychologist • Individual Presented: - Individual #567 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; Nedra Francis, Assessment Psychologist; Norvell Starling, MISD/MSSLC Liaison; Eileen Farber, Psychiatrist; Chris Christensen, Psychologist; Xiaodong Zhang, Psychologist; Lupita Alfaro, Psychologist Assistant; Joann Cooper, Res. Services Program Auditor; Trey Stubbs, Psychologist; Andrew Griffin, Psychologist, Terri Moon, QA. • Individuals Presented: - Individual #161, Individual #431, Individual #268, Individual #539 o Peer Review meeting • Staff Present: - Charlotte Kimmel, Director of Psychology Services, Michael Grimmett, Psychologist; Molly Chase, Psychologist; Lupita Alfaro, Psychologist Assistant; Trey Stubbs, Psychologist; Andrew Griffin, Psychologist, Terri Moon, QA; Michael Miller, Psychologist; Ora Davis, Psychologist. • Individual Presented: - Individual #142 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; 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 substantial compliance for items K2 and K3, and noncompliance for the remaining items of this provision. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's self-assessment. 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 two of the items in this provision were found to be in substantial compliance with the Settlement Agreement, there were several improvements since the last onsite review. These include: • Increase in the number of staff enrolled in BCBA coursework (K1) • Addition of internal and external peer review (K3) • The expansion of a simplified data system across the majority of homes (K4) • The use of more sensitive data presentation (K4) • Improvements in functional assessments (K5) • The development of a new psychological assessment format for annual updates (K7) • Improvements in Positive Behavior Support Plans (K9) • Discussions have begun to clarify what behavior procedures can be used at MSSLC The monitoring team believes that areas that are most in need of improvement are: • Ensuring that all group and individual therapies are based on evidence-based procedures, and services are goal directed with measurable objectives and treatment expectations (K8) • Ensuring that data are reliably collected (K4, K10) • Ensuring that PBSPs are implemented with integrity (K11) • Systematic training of all direct care professionals (DCPs) in the implementations of each individuals PBSP (K12) • Ensuring that all functional assessments include all the necessary assessment components and have a clear summary of the variables hypothesized to affect target behaviors (K5) • Ensuring that all Positive Behavior Support Plans (PBSPs) are based on the hypothesized function of the target behavior, and specify clear, concise antecedent and consequent interventions (K9)

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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 at MSSLC were not demonstrably competent in applied behavior analysis (ABA) as evidenced by the absence of professional certification, and the lack of consistent quality of the Positive Behavior Support Plans (see K9). At the time of the onsite review, no members of the Psychology Department were board certified behavior analysts (BCBAs). Seven of the department's 19 psychologists, however, were enrolled in course work toward becoming BCBAs. Three additional psychologists had been approved to sit for the national exam. Eight of the remaining nine psychologists have committed to begin taking BCBA coursework in the fall. The facility provided supervision of psychologists enrolled in the BCBA program by contracting with a consulting BCBA from the community. To achieve compliance with this item of the Settlement Agreement the department needs to ensure that all psychologists who are writing Positive Behavior Support Plans (PBSPs) 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 continued to be in 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, improvements in the data system, establishment of peer review) 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.	MSSLC has attained substantial compliance with this item. MSSLC had recently begun a weekly internal, and monthly external, peer review meeting. The facility had been conducting Behavior Therapy Committee/Peer Review (BTC) meetings that contained many of the elements of internal peer review, however, these meetings only reviewed PBSPs that required annual approval. The newly established internal peer review meetings provided an opportunity for psychologists to present cases that were not progressing as expected. The peer review meetings also allowed more time to discuss cases.	Substantial Compliance

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		The peer review meeting observed by the monitoring team reviewed one individual (i.e., Individual #142), included participation by the majority of the psychology department, and included a BCBA from another SSLC. The peer review included active participation among the psychologists, and resulted in the identification of several new antecedent and consequent procedures to address Individual #142's target behaviors. Review of minutes from these meetings indicated that internal peer review meetings were attended by the majority of psychologists in the department. Additionally meeting minutes indicated internal peer review meetings consistently occurred weekly, and that once a month (since January of 2011) these meeting included a BCBA from outside the facility, therefore, achieving the requirement of monthly external peer review meetings. Operating procedures for both internal and external peer review committees were established. The monitoring team will review meeting minutes to ensure that internal peer review consistently occurs weekly, and external peer review consistently occurs at least monthly to maintain substantial compliance with this provision item.	
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.	There were several improvements in this provision item since the last onsite review. More work, however, is necessary before the facility achieves substantial compliance. As recommended in the last report, the facility had expanded the simplified data system that it had introduced just prior to the last onsite review. The monitoring team found the new data system in every home except for S1 (i.e., Individual #227's data sheet). It is recommended that the new data system be expanded to all individuals and homes at MSSLC. There were several advantages to the new data system. The new data system documented target behaviors in 30-minute intervals, and was substantially easier to complete than the previous ABC system that required the recording of each target behavior's antecedent and consequences. All direct care professionals (DCPs) asked, indicated that they found the new system easier to use than the ABC system. Additionally, in the new data system DCPs were required to record a zero or their initials in each recording interval if target or replacement behaviors did not occur. This method ensured that the absence of target behaviors in any given interval did not occur because staff forgot to record the data. This requirement also allows the psychologists to review data sheets and determine if DCPs were recording data at the intervals specified. The monitoring team sampled individual data sheets in 15 homes across the facility. Only three (i.e., two individuals' data sheets in L6, and one in L1) of 17 data sheets reviewed (6%) contained current target and replacement behavior data. Many of the data sheets reviewed did not have data recorded for multiple days. This result indicates that data were not consistently recorded immediately after the target and replacement	Noncompliance

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		behaviors occur, increasing the likelihood it is unreliable. In fact, all the psychologists interviewed indicated that they did not have confidence in the data collected. A hallmark of applied behavior analysis (ABA) is the use of data-based decisions. Meaningful data-based decisions are impossible, however, if the data are not reliable. The absence of data-based treatment decisions was obvious in two psychiatric clinics observed by the monitoring team. In one psychiatric clinic the psychiatrist was attempting to determine if Individual #24 should remain on his medication. Graphed data of his target behaviors were available, however, they were not current (they were over two weeks old). The psychiatrist asked if the behavior was continuing to occur and the psychologist stated that it was not. The QMRP however, responded that he thought the behavior had recently occurred. The absence of current, reliable data prevented the psychiatrist from making a data-based treatment decision. In another psychiatry clinic (for Individual #567), no graphed data were available for the psychiatrist to review. As discussed in the last report, the addition of data collection reliability described above (which assesses whether data are recorded), along with interobserver agreement data (which assesses 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 to track data collection reliability and interobserver agreement (IOA) data for all target and replacement behaviors in each home and day/vocational site. Additionally, specific data collection compliance and IOA goals should be established, and feedback and training should be provided to DCPs and their supervisors to ensure that data are reliability collected. The facility currently uses only frequency measures of target and replacement behaviors. As discussed in the last report, in order to be most useful for making data-based decisions, the data system also needs to be more sensitive to each individual's needs. That is the data system needs to be able to accurately assess both behaviors that occur at low rates, as well as behaviors that occur at such high rates (e.g., stereotypes, undesirable verbal behavior) that frequency would be very difficult to measure. 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. As recommended in the last review, MSSLC had begun to graph data in increments based on individual needs. For example, Individual #491's frequency of restraints was graphed in hourly increments to better understand the behavior's relationship to meal times.	

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		Additionally, the monitoring team encountered a few graphs where medications and other potentially important events (e.g., changes in the PBSP) were indicated with phase lines, resulting in easier interpretation of the data (e.g., Individual #519's self-injurious behavior). The monitoring team was encouraged by these improvements in the data system at MSSSLC, and looks forward to seeing more examples during the next onsite review. In reviewing six months of PBSP data for five individuals, four (Individual #519, Individual #398, Individual #491, Individual #161), or 80%, indicated no obvious improvement in severe behavior (e.g., aggression or self-injurious behavior) and no indication of corrective action (e.g., retraining of staff on the implementation of the PBSP, a change in PBSP interventions, an attempt to collect additional data to better understand the variable or variables affecting the target behavior, etc.) other than at the annual PBSP review. In fact, none of the 24 PBSPs reviewed indicated a revision (or other corrective action) due to lack of progress (other than at annual reviews). It is important that when individuals' data trend in an undesirable direction (or continues with no improvement), that hypotheses be developed, changes be made, and that any discussion and intervention are documented in the progress notes.	
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 because psychological assessments were not completed for every individual, and because of the need for the content of many functional assessments to be more comprehensive and complete. <u>Psychological Assessments</u> As indicated in the last report, 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. A spreadsheet including initial psychological assessments completed indicated that approximately 78, of the 393 individuals (20%) at MSSLC had initial psychological assessments. This represents an improvement over the 57 initial psychological assessments completed during the last onsite review. Ten initial psychological assessments were reviewed by the monitoring team. • All 10 (100%) included a standardized assessment of intellectual and adaptive ability, and an assessment of psychopathology, and a personal history. • Four of 10 (40%) of the initial psychological assessments reviewed contained an	Noncompliance

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		assessment of medical status. Each individual's record should contain a psychological assessment that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status. <u>Functional Assessments</u> As indicated in the last report, not all individuals with a PBSP had a functional assessment. All individuals with a PBSP should have a functional assessment of the variable or variables affecting the individual's target behaviors. Eight functional assessments were completed since the last review, and were used to assess compliance with this item of the Settlement Agreement. Review of these functional assessments indicated that the majority of issues identified in the last review still existed. As reported in the last two reviews, multiple formats of functional assessments were found. Individual #519's functional assessment format was different than the other seven functional assessments reviewed. It is recommended that all functional assessments at the facility use the same format. As discussed below, the majority functional assessments conducted since the last onsite review did contain all of the necessary elements of a functional assessment identified in the last report. The quality of some of these elements, however, was insufficient for the functional assessments to be as effective as they could be. The direct assessment procedures of five (i.e., Individual #21, Individual #183, Individual #142, Individual #398, and Individual #591) of the eight functional assessments reviewed (62%) were not complete because they did not specify antecedents prior to the target behavior(s) and/or consequences after it occurred. Some of these direct assessments (e.g., Individual #398 and Individual #21) contained multiple direct observations by the psychologist, but they were not conducted often enough to observe the target behaviors and provide any additional information about relevant antecedent or consequent events affecting the target behavior. On the other hand, two (25%) of the direct functional assessment measures reviewed (i.e., Individual #491, Individual #519) appeared to be particularly useful for identifying potential variables affecting the target behavior. Both included the collection and graphing of hourly data to better understand if the target behaviors were related to times of the day. For example, this analysis was useful for identifying that Individual #491's target behaviors were related to mealtime. Another potentially effective way to collect direct functional assessment data is to use ABC (i.e., the systematic collection of both antecedent and consequent behavior) data. In	

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		order to be useful, however, ABC data would need to be collected long enough to observe several examples of the of the target behavior, so that patterns of antecedents and consequence could be identified. All functional assessments should contain complete direct measures of the target behaviors. Seven of the eight functional assessments reviewed (88%) identified potential antecedents and consequences of undesired behavior. All functional assessments should identify operationally defined potential antecedents and consequences of the target behavior. One of the remaining seven functional assessments reviewed (14%) identified antecedents of the identified events, however, they were not operationally defined and, therefore, not useful for understanding the variables maintaining the behavior. For example, Individual #142's functional assessment concluded that the function of his rage reaction was the release of anxiety built up from a chaotic environment. These general statements would likely have different meanings to different people and, therefore, are not very useful for understanding the function of Individual #142's undesired behavior. Four of the eight functional assessments reviewed (50%) did not include a summary statement. All functional assessments should include a summary statement that integrates the results of the various assessments into a comprehensive statement of the variables affecting the target behaviors. Two of the remaining four functional assessments reviewed (50%) included summary statements that were not based on operationally defined behaviors identifying the variable or variables maintaining the target behavior (e.g., see above comments on Individual #142's functional assessment), or the summary statement did not appear complete. For example: • Individual #441's indirect assessments repeatedly identified negative reinforcement as a function of several of his undesired behavior, however his summary statement simply stated that his aggression was likely a function of attention. Additionally, several target behaviors, discussed in the indirect assessment and listed as target behaviors (e.g., rage reaction, self-injurious behavior, instigation, noncompliance), were not mentioned in the summary statement. Clearly, when comprehensive functional assessments are conducted there are going to be some variables identified or suggested that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. Although two of the functional assessments reviewed were otherwise comprehensive (e.g. Individual #491 and Individual #519), they did not clearly and concisely integrate the information into a summary statement identifying the variables (both antecedent and	

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		consequent) that were hypothesized to affect the behavior. Four of the eight functional assessments reviewed used a chart to organize the conclusions of the functional assessment. Three of those charts only used part of the sample chart presented in the Structural and Functional Assessment Report template from DADS (Policy #008), and their utility was unclear to the monitoring team. When the monitoring team asked one of the psychologists to explain the chart, the psychologist did not understand it. It is suggested that the facility either use the chart as presented in the DADS policy so that it is useful for summarizing information, or simply ensure that all relevant information is included in a summary statement. There was evidence that functional assessments at MSSLC were reviewed and modified when an individual did not meet treatment expectations. Individual #441's functional assessment indicated that it was written on 1/8/10 and revised on 11/15/10. 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 (with a maximum of one year between reviews). None of the functional assessments reviewed (0%) were evaluated to be comprehensive and clear. Several functional assessments, however, contained excellent components that should be modeled for future reports. Those include: • Individual #491's direct assessment of the relationship between mealtime and undesired behavior. • Good comprehensive summary statements for Individual #398 and Individual #591. • Excellent indirect measures for Individual #21, Individual #398, Individual #491 and Individual #519's functional assessments. • Overall Individual #491 and Individual #519's functional assessments were very good. They did not, however, contain summary statements and Individual #519's functional assessment used a different format that the monitoring team found particularly difficult to follow.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	MSSLC's psychological assessments were not based on complete clinical and behavioral data (see K5 and K7) and, therefore, this provision item was rated as being in noncompliance.	Noncompliance
K7	Within eighteen months of the	Psychological assessments were not completed for every individual at MSSLC (see K5)	Noncompliance

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	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.	and, therefore, this provision item was rated as being in noncompliance. Additionally, three of the 10 (30%) initial psychological assessments reviewed included intellectual assessments that were more than 10 years old. DADS and the monitoring team are determining the conditions for conducting new assessments. Future reviews will evaluate the timeliness of psychological assessments based on those guidelines. MSSLC had completed 11 annual psychological updates (3% of individuals) at the time of the onsite review. The facility had recently modified the format for annual updates, and no assessments in the new format were available for review at the time of the onsite review. Annual psychological updates, in the new format, will be reviewed in future reviews. It is recommended that all individuals receive annual psychological updates. The purpose of the annual update is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should 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 has recently revised the annual psychological updates format to include each of these components. Again, no annual assessments in the new format were available for review at the time of the onsite review. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of two recent admissions (Individuals #471 and Individual #31) to the facility indicated that this component of this provision item was in substantial compliance.	
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. The need for psychological services other than PBSPs were documented in psychological assessments (e.g., Individual #136), PBSPs (e.g., Individual #183), and PSPs (e.g., Individual #82). 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 and PSAS evidence-based curriculum was	Noncompliance

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		begun in 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, 143 individuals received one of these psychological services. The treatment plans for 14 of these individuals were submitted by the facility and were reviewed. As found in the last review, all treatment plans included a general purpose and plan, but did not meet the criteria listed below. One treatment plan (i.e., for Individual #383) also contained specific objectives and treatment expectations. It is recommended that the facility continue to work in this area to ensure that counseling/ psychotherapy services for all individuals include: • a treatment plan that includes an initial analysis of problem or intervention target • measurable objectives and treatment expectations • evidence-based practices • documentation and review of progress • a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings The monitoring team also strongly recommends that the MSSLC psychology department collaborate with the San Angelo SSLC psychology department regarding the requirements of this provision item (i.e., the provision of psychological services other than PBSPs) as well as all of the other items of this provision. Working together will allow for consistency, sharing of best practices, and an increase in the SSLC system's likelihood to treat these individuals in an effective manner.	
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	This item was rated as being in noncompliance because not all PBSPs reviewed contained all of the components necessary for an effective plan, and many of the interventions were not clearly based on functional assessment results. Of the 24 PBSPs reviewed, 20 were completed or updated since the previous review, and therefore, were the focus of this review for evaluating improvement since the last report. Every PBSP reviewed had the necessary consent and approvals. All of the PBSPs contained descriptions of data collection procedures, baseline data, and treatment expectations and timeframes. Multiple formats of the PBSP were used. Individuals #491, #519, #508, and #398's PBSP format was different than the other PBSPs reviewed. It is	Noncompliance

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	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 written extension based on extraordinary circumstances.	recommended that a single format be used. All PBSPs reviewed included descriptions of target behaviors, however, four (20%) of these were not operational. For example: • Individual #21's PBSP defined aggression as "…harassing others…slamming doors….behaviors intended to hurt others." This definition required the reader to infer if Individual #21 did indeed have an intention to harm others. It also required DCPs to determine if Individual #21 was harassing others. An operational definition should not require DCPs to infer an individual's intentions. An operational definition should only include observable behavior (e.g., hitting, pushing). Finally, the operational definition of aggression toward others included slamming doors. It is not clear how slamming doors is related to physical aggression toward others. • Individual #591's PBSP included a target behavior of self-injurious behavior (SIB) that included behaviors intended to cause injury to self. On the other hand, the majority of PBSPs contained operational definitions that were operational, clear, and complete. Examples included: • Individual #161's physical aggression was defined as hitting with hand/fist, running into people with his wheelchair. • Individual #303's SIB was defined as "…hitting herself on the head or face, biting her fingers, hands and wrists." All PBSPs should include operational definitions of target behaviors. All 20 of the recent PBSPs described antecedent and consequent interventions, but only seven (35%) were rated to be useful for treating the undesired behavior. Examples of ineffective interventions included: • Individual #303's PBSP hypothesized that her undesired behaviors were maintained by negative reinforcement (i.e., a way to escape unpleasant activities), but her intervention following target behaviors included moving her to a quiet area. If her aggression was maintained by negative reinforcement, then this intervention would encourage, rather than discourage, her undesired behavior because it allowed her to escape unpleasant activities by engaging in undesired behavior. • Individual #146's PBSP did not contain a description of the hypothesized function of his targeted behaviors. Since it was not based on the function of his behavior, his PBSP appeared very general and likely would not weaken his undesired behavior.	

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		An example of a PBSPs that was based on the hypothesized function of the targeted behavior and, therefore, likely to result in the weakening of undesired behavior was: • Individual #491's PBSP hypothesized that her physical aggression functioned to gain attention and obtain desired objects. Antecedent interventions included reinforcing alternative, desirable behaviors with the same events maintaining her aggression. For example, her PBSP specified that she should be provided praise and desired items when she communicated her wants and needs without displaying aggressive behavior. Additionally, her PBSP included that every hour without aggression she would be given positive verbal attention for two to three minutes and a choice of reinforcers. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior. All of the PBSPs reviewed included the use of reinforcers. Replacement behaviors were included in all of the 20 PBSPs (100%) reviewed. Replacement behaviors should be functional, whenever possible and appropriate. That is, they should represent desired behaviors that serve the same function as the undesired behavior. The monitoring team found that 14 of the 20 PBSPs (70%) contained replacement behaviors that were functional. An example of a functional replacement behavior was: • Individual #161's physical aggression was hypothesized to be maintained by staff attention. His replacement behavior included teaching him to gain attention by appropriate means and in a socially acceptable manner. This was a good example of a functionally equivalent replacement behavior because it provided the same reinforcer (i.e., an alternative way to gain staff attention) that was hypothesized to be maintaining the target behavior. An example of a replacement behavior that was not functional was: • Individual #591's targeted behaviors were hypothesized to be maintained by negative reinforcement. His replacement behavior included following instructions. Increasing compliance appeared to be an important behavior for Individual #591, however, it was not functionally equivalent to the purposed function of his target behavior (i.e., escaping undesirable activities). An example of a functional replacement behavior for a target behavior maintained by negative reinforcement would include teaching him an appropriate way to postpone or terminate a demand.	

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		As reported in the last review, 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, although Individual #161's replacement behavior was functional, it consisted of teaching him to gain attention by appropriate means and in a socially acceptable manner. All DCPs, however, may not interrupt "gain attention by appropriate means" 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 included 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). Overall the monitoring team identified five (Individual #491, Individual #519, Individual #589, Individual #113, Individual #398) of the recent PBSPs (25%) to be good examples of plans that had operational definitions of target behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. It is recommended that the facility build on these PBSPs and, for the next review, focus on increasing the percentage of PBSPs that are representative of clear, concise plans based on the results of a functional assessment. In the last monitoring report, in response to staff expressing confusion as to what interventions they could and could not implement to decrease undesired behavior, the monitoring team suggested that the facility develop a list of interventions that were allowed (and the conditions necessary to implement them) and those that were prohibited. During the onsite review, the director of psychology indicated that the facility was making progress on developing this list. The monitoring team looks forward to reviewing the list of potential interventions during future onsite reviews.	
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	Interobserver agreement measures were not collected for target and replacement behaviors at the time of the onsite review (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, the facility had begun to graph some individual's data in increments that would be sensitive to individual needs and situations (e.g., daily or weekly graphed data to assess	Noncompliance

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	efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	the changes associated with a change in medication or target behaviors), and some graphs were easier to understand because potentially important events (e.g., change in plans or medication) were indicated with phase lines or arrows. The facility is encouraged to expand these graphing practices to all individuals' data that require a more sensitive graphing increment and/or a cleaner, more readable graph. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path.	
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, at the time of the onsite review, the facility did not demonstrate that PBSPs were reliably implemented by DCPs. As discussed in the last report, MSSLC has begun a process of reviewing each PBSP and attempting to eliminate unnecessary target behaviors, and simplifying the interventions. Additionally the facility monitors the reading level of each PBSP and has established a reading level of 6th grade as the standard for all PBSPs. This process will likely result in more practical and useful PBSPs that are more likely to be implemented with integrity by DCPs. The only way to ensure, however, that PBSPs are implemented as written is to implement a system to monitor treatment integrity. As discussed in the last report, MSSLC had made progress on this provision item by introducing a system to monitor and ensure treatment integrity. The tool involved asking staff specific questions about the PBSP, such as regarding antecedent behaviors and replacement behaviors. The integrity system also included direct observations of staff implementing PBSPs. In order to ensure that all staff have been trained, integrity trends have been identified, and all staff are implementing PBSPs with integrity, it is recommended that integrity data be tracked and maintained centrally, the data reviewed regularly, and minimal acceptable integrity measures established. There were no integrity data available for review during the onsite review. The monitoring team looks forward to reviewing integrity data during the next onsite review.	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	As reported in the previous review, the psychology department maintained logs documenting staff members who 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. Additionally, the facility added a competency based staff training component. Although improving, more work in this area	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.	is needed to achieve substantial compliance with this item. There was no system in place to ensure that all staff (including relief staff) had been trained. Additionally there was no systematic way to identify all of the staff who required remedial training. In order to meet the requirements of this provision item, the facility will require documentation that all staff assigned to work with an individual has been trained in the implementation of their PBSP prior to PBSP implementation, and at least annually thereafter. Additionally, the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence 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 review, MSSLC had a census of 393 individuals and employed 19 psychologists responsible for writing PBSPs. Additionally, the facility employed eight psychology assistants and six psychology technicians. None of these psychologists, however, had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least 10 psychologists with BCBAs.	Noncompliance

Recommendations:

1. The facility should ensure that all psychologists responsible for writing PBSPs attain BCBA certification.
2. The new simplified data system should be expanded to all homes and individuals.
3. It is recommended that the facility begin to track data collection reliability and interobserver agreement (IOA) data for all target and replacement behaviors in each home and day/vocational site. Additionally, specific data collection compliance and IOA goals should be established, and feedback and training should be provided to DCPs and their supervisors to ensure that data are reliability collected.
4. The facility should expand its data collection system to allow it to accurately assess the occurrence of all target and replacement behaviors.
5. It is recommended that when individuals' data trend in an undesirable direction (or continues with no improvement), that hypotheses be developed, changes be made, and that any discussion and intervention be documented in the progress notes.
6. Each individual's record should contain a psychological assessment that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status.
7. All individuals with a PBSP should have a functional assessment of the variable or variables affecting the individual's target behaviors.

8. All functional assessments should use the same format.

9. All functional assessments should contain complete direct measures of the target behaviors.

10. All functional assessments should identify operationally defined potential antecedents and consequences of the target behavior.

11. All functional assessments should include a summary statement that integrates the results of the various assessments into a comprehensive statement of the variables affecting the target behaviors.

12. Functional assessments should be revised when new information is learned concerning the variables affecting an individual's target behaviors.

13. Functional assessments should be reviewed at least once a year.

14. All individuals should receive annual psychological updates.

15. It is recommended that the facility ensure that counseling/ psychotherapy services for all individuals include:
    - a treatment plan that includes an initial analysis of problem or intervention target
    - measurable objectives and treatment expectations
    - evidence-based practices
    - documentation and review of progress
    - a "fail criteria"— that is, a criteria that will trigger review and revision of intervention
    - procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings

16. All PBSPs should use a single format.

17. All PBSPs should include operational definitions of target behaviors.

18. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior.

19. All replacement behaviors should be functional when practical and possible.

20. It is recommended that all replacement behaviors include specific skill acquisition plans for training. These plans should be included into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility.

21. Integrity data should be tracked and maintained centrally, the data reviewed regularly, and minimal acceptable integrity measures established.

The following are offered as additional suggestions to the facility:

22. 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.

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

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 7/20/10 o DADS Policy#006.2: At Risk Individuals, 12/29/10 o DADS Policy#09-001: Clinical Death Review, 3/09 o DADS Policy #09-002: Administrative Death Review, 3/09 o DADS Policy #044: Medical Emergency Response, 7/21/10 o MSSLC Policies and Procedures Manual Medical – 8, Referrals to Alternative Health Care Facilities for Non-Emergency Medical Services, 3/15/10 o MSSLC Policies and Procedures Manual Medical – 16, Medical Services, 11/1/10 o MSSLC Policies and Procedures Manual Medical o MSSLC Policies and Procedures Manual Medical o Mortality Reviews for individuals who died between July 2010 and January 2011 o Listing, Individuals with seizure disorder, status epilepticus o Listing, Individuals diagnosed with pneumonia o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Individuals diagnosed with osteoporosis or osteopenia and treatment regimen o Listing, Individuals with diabetes mellitus o Listing, Individuals diagnosed with cancer o Listing, Individuals with DNR Orders o Scott & White Temple Neurology Clinic Notes for 5 individuals o Listing, Individuals hospitalized and sent to emergency department o DEXA reports for individuals with osteoporosis and osteopenia o Components of the active integrated record - annual physician summary, active problem list, preventive care flow sheet, immunization record, hospital summaries, active x-ray reports, active lab reports, psychiatric assessments, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, health management plans, diabetic records, seizure records, vital sign sheets, bowel records, MARs, annual nutritional assessments, dental records, annual PSPs, and PSP addendums for the following individuals: • Individual #252, Individual #295, Individual #432, Individual #420, Individual #89, Individual #79, Individual #86, Individual #70, Individual #96, Individual #188, Individual #197, Individual #477 o Employee Training Roster, Documentation of Non-Facility Consults o Medical workload data o Tracking log for non facility consults October 2010 – February 2011

	Interviews and Meetings Held: o Dolores Erfe, MD, Medical Director o Victor Vines, MD, Primary Care Physician o Yenni Michel, DO, Primary Care Physician o Jose Ruiz, MD, Primary Care Physician o Ernie Atkins, DO, Primary Care Physician o Onyinye Agim, MD, Primary Care Physician o Christopher Ellis, MD, Primary Care Physician o Eileen Farber, MD, Psychiatrist o Kendall Brown, MD, Psychiatrist o Wanda Michaels, MD, Psychiatrist o Woodrow Coppedge, MD, Psychiatrist o Norris Buchmeyer, RN, Chief Nurse Executive Observations Conducted: o Presentation made to monitoring team by senior staff at MSSLC at opening meeting o Daily medical staff meetings o Cottages and dorms o Day services areas
	Facility Self-Assessment: The facility rated itself noncompliant in all provisions of the Settlement Agreement. The monitoring team agrees with the facility's rating due to several areas that require improvement such as risk identification and management, communication of accurate medical information, and seizure management. Policies and procedures are needed prior to implementation of a medical quality program and the mortality review system must be strengthened.
	Summary of Monitor's Assessment: Progress was noted in the provision of medical services. Overall, individuals received appropriate routine and preventive care although there were some deficiencies noted in areas, such as colorectal cancer screening and breast cancer screening. A comprehensive seizure management program had not been implemented, but more individuals were having outside neurology appointments. The Neurology Physician Assistant from Scott & White had been to the facility and a follow-up phone conference was completed for one individual. This presented new treatment options for this individual with intractable seizure disorder. An external review was completed just prior to the onsite review and audits of records were done across the caseloads of all six physicians. This should provide valuable feedback to the primary care physicians. Mortality reviews were completed, but there continued to be concerns with implementation and follow-up of recommendations.

	Clinical guidelines were in the process of development but had yet to be implemented. Development of a medical quality program was contingent upon this process.

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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.	**Overview** The medical staff included a full time medical director, six primary care physicians (PCP) and four fulltime psychiatrists. PCPs 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 home to record who needed to be seen. The medical staff met daily to review pertinent events, conduct medical reviews, and participate in hospital reports. Labs were drawn and processed at the facility and sent to Austin State Hospital. Stat labs were done at a local hospital and results were available in two to four hours. In October 2010, the radiology department installed a digital imaging system. Software was installed on the computers of the PCPs that allowed them to review x-rays from their offices. Images were transferred to CD and couriered to Waco on weekdays. Final reports sometimes took up to two weeks to become available. Individuals who required acute care or admission were transferred to a local hospital. The facility maintained a hospital liaison program through nursing services. The record sample, listed above in the Steps Taken section of this report, was chosen using the following methodology: • Records were randomly selected from the various lists of individuals submitted by the facility. **General Medical Care and Documentation** The individuals received a variety of medical services. They were provided with preventive services; specialty care and acute care were available. <u>Annual Medical Assessments</u> Annual medical assessments were found in every chart reviewed. Eleven of 12 records contained assessments that were completed within the required timeframes. <u>Active Problem List</u> Active problem lists were found in all of the records contained in the record sample. It appeared that the document was primarily being updated at the time of the annual medical assessment. The Health Care Guidelines required that the active problem list be	Noncompliance

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		updated continuously as problem status changes. Integrated Progress Notes Notes were written in SOAP format, timed, and dated. There was frequent documentation in the records by the medical staff. Consults were often briefly summarized and abnormal findings noted. Quarterly Summaries Quarterly summaries were not completed at the facility. The medical director stated that a format was under development. Physician Orders Physician orders were signed, timed, and dated. Incomplete orders were noted in the record sample reviewed. Further discussion and examples of such incomplete orders are provided in section N1. Additional Discussion The annual assessments were completed based on a standardized template. It contained information on history of preset illness, active problems, medications and a plan of care. The annual assessment did not provide a good snapshot of the individual's health status. Problems and diagnostics were usually not connected and medical risks were not discussed. Organizing this information would likely improve the quality of the document. Inserting an interval history (what has occurred since the last annual assessment) provides one way of linking all relevant information. Discussion of an individual's interval health history should be organized by active health problems with information presented chronologically. All history – illnesses and other events, diagnostic tests, surgeries, interventions, consultations, medication trials, etc. – should be documented in the discussion of each active health problem. Health issues that are related to each other (e.g., dysphagia, aspiration, pneumonia) should be discussed together. In addition to the interval history, consideration should be given to adding a section on medical risks (e.g., osteoporosis, aspiration). Physicians should assess for risks, look for ways to mitigate risks, and implement plans of care. This is done within the framework of the "risk process," but a summary should be included in the annual medical assessment. When individuals have off campus appointments, vey little information went with them – annual assessment, active problem list, and current medications. These documents	

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		provided critical information to health care providers who must make decisions and provide answers. It is imperative that the information be accurate and complete. Medical policy required a transfer packet to be sent to hospitals or receiving agencies and should include the copy of the latest Annual Medical Assessment, Active Problem List, profile sheet, list of current medications and a cover sheet indicating the reason for the individual's referral. The medical director should collaborate with the CNE to ensure that this occurs. **Routine and Preventive Care** Overall, the provision of preventive services was good. Screenings (audio and visual) and immunizations were provided with high compliance rates. Screenings for breast cancer and colorectal cancer were being completed and the number was increasing. In many instances, there was an explanation provided by the PCP when the screening was not completed. This area needs additional review by the medical director to ensure that the risk/benefit analysis has been adequately conducted. There were problems noted, however, in the area of follow-up of routine issues and chronic medical problems. Additionally, several consultants at Scott & White documented in consultation reports that information was not available. Examples are provided later in this section of the report, under case reviews. <u>Screenings</u> • 12 of 12 records contained documentation of appropriate vision and hearing screenings • 2 of 8 males met criteria for PSA testing o 2 of 2 males had current PSA levels documented <u>Breast Cancer Screening</u> • 3 of 4 females were within the age range for screening mammography • 2 of f 3 females had completed mammography A list of all females over the age of 40, date of last mammogram, and reason for noncompliance was provided. The list contained 76 individuals: • 39 of 76 females had completed breast cancer screening • 14 of 76 females were over the age required • 12 of 76 females refused • 8 of 76 females were awaiting orders • 3 of 76 females had appointments cancelled	

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		Colorectal Cancer Screening • 5 of 12 individuals were over the of 50 • 4 of 5 had fecal occult blood testing documented • 0 of 5 individuals had completed colonoscopies A list of all individuals over the age of 50 was provided. The list contained 73 individuals: • 19 of 73 individuals had undergone colonoscopy within the last 10 years. One individual on the list completed a colonoscopy in 1996. • 12 of 19 individuals had the colonoscopy done as a part of their preventive health care. • 7 of 19 individuals had the colonoscopy performed due to anemia or an existing diagnosis • 54 of 73 individuals had no record of a colonoscopy within 10 years o 43 of 54 individuals had not been completed, but fecal occult blood testing and rectal exams were being completed o 8 of 54 individuals were awaiting orders or scheduling o 2 of 54 individuals refused testing o 1 of 54 individuals was a new admission Immunizations • 11 of 12 individuals received influenza and pneumococcal vaccinations. • 12 of 12 individuals had documented immunity against Hepatitis B. • 0 of 12 individuals had documented evidence of immunity to varicella or administration of varicella vaccination • 4 of 4 individuals over the age of 60 received the Zoster vaccination The CDC recommends varicella vaccination for all healthy persons over the age of 13 without evidence of immunity. Additional Discussion The colonoscopy-tracking log indicated that screening colonoscopies for individuals with no family history would be done every 10 years. Baseline colonoscopies were to be ordered between ages 50 and 61, unless hem occult /rectal exam indicated a problem. Consideration was given to the risk benefit analysis of performing the procedure.	

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		Medical Management <u>GERD</u> • 4 of 12 individuals were diagnosed with GERD • 4 of 4 individuals with GERD received appropriate medical therapy <u>Osteoporosis</u> • 5 of 12 individuals had a diagnosis of osteoporosis o 5 of 5 individuals received appropriate medical management and • 1 of 12 individual had a diagnosis of osteopenia o 1 of 1 individuals received appropriate medical management A list of all individuals with osteoporosis and osteopenia was provided • 62 individuals were diagnosed with osteoporosis o 59 of 62 individuals received treatment with Alendronate o 1 of 62 individuals received treatment with Raloxifene o 1 of 62 individuals received treatment with calcium citrate and ergocalciferol o 1 of 62 individuals received treatment with calcium carbonate and Vitamin D • 5 individuals were diagnosed with osteopenia o 5 of 5 individuals received calcium supplementation o 4 of 5 individuals received additional treatment with Alendronate and/or Vitamin D <u>Diabetes Mellitus</u> • 3 of 12 individuals had a diagnosis of diabetes mellitus o 1 of 3 individuals received appropriate medical management and monitoring o 1 of 3 individuals received no medication and had normal HbA1c levels. Dietary restrictions were removed. o 1 of 3 individuals received appropriate medical therapy but monitoring was not appropriate <u>Hypertension</u> • 3 of 12 individuals had a diagnosis of hypertension • 2 of 3 individuals received appropriate medical management and monitoring • 1 of 3 individuals had less than optimal management of hypertension	

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		Bowel Management • 8 of 12 individuals had a diagnosis of constipation. • 5 of 8 individuals received 3 drugs for management o constipation • 3 of 8 individuals received 2 drugs for management of constipation • Individual #89 was admitted to the hospital with a diagnosis of adynamic ileus. The individual received two medications for treatment of constipation, but had never had a colonoscopy performed. • Individual #79 was admitted with a small bowel obstruction. This individual received three medications for treatment of constipation, but never had any diagnostics for further evaluation of chronic constipation. • Individual #96 was admitted with a idiopathic colon perforation. This individual received one medication on a regular basis for treatment of constipation, but did not appear on the facility's constipation list. A list of individuals with a diagnosis of constipation was provided. The document contained a list of 97 individuals. This list was compared to 30 documents listed under DRRs in Section N. There were six individuals included in the DRR documents who received multiple medications for treatment of constipation, but who were not included in the facility listing of constipation: Individual #303, Individual #231, Individual #390, Individual #375, Individual #341, and Individual #229. These examples illustrate the facility's need for clinical guidelines related to bowel management. **Case Synopses** Summaries of several of the 12 records reviewed are provided below. Each synopsis highlights both positive and negative aspects of care. • Individual #477 had multiple medical conditions including diabetes mellitus, hypertension, hyperlipidemia, osteoporosis, and dysphagia. The individual was treated with two medications for constipation, but the diagnosis was not included in the active problem list or annual medical assessment. Appropriate vaccinations were provided as well as screening for vision and hearing. Pap testing was discontinued. This individual had documented episodes of hypoglycemia and was followed by an endocrinologist. At an appointment on 10/5/10, the endocrinologist documented, "There are reports that the patient still has hypoglycemic episodes but unfortunately I do not have any of the blood glucose readings." Colorectal cancer screening was done with FOB. This individual also was treated for a diabetic foot ulcer in 2010 and the PCP documented the diagnosis in the progress notes. The annual medical assessment and problem list did not mention a history of the ulcer, which can	

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		have serious implications in a diabetic individual. The following is the assessment and plan from the most recent annual medical assessment on 10/19/10: 1. Type II Diabetes – good control. Also takes Metformin and Glucotrol. Client receives annual eye exams and podiatry clinic exams quarterly. 2. Epilepsy – takes Dilantin and Neurontin. Last seizure 7/09. 3. Hypertension – good control with lisinopril 4. Hyperlipidemia – last lipids 4/09 5. Osteoporosis – history of DVT. Pt on coumadin with decent control. 6. Preventive services- annual exam, physician exam … mammogram and colon cancer screening 7. Stasis edema – pressure stockings <u>Additional Discussion</u> o There was no documentation of renal function, urine microalbumin, or urine protein/creatinine ratio. o Hyperlipidemia – last lipids in 4/09. Results from 4/10 were documented. No liver enzymes were mentioned in the document (monitoring for adverse reactions). o Osteoporosis – did not mention last BMD results or Vitamin D level. o There was no fecal occult blood testing documented in assessment. o This individual, who was diabetic, was treated for a foot ulcer in 2010, but that was not documented in the annual medical assessment and it should have been. o Anemia – Hb 11.8 and Hct of 33.8 MCV 101.9. Neither the etiology nor evaluation of the anemia was discussed in the assessment. o The reason for not completing a colonoscopy was not provided. o Heart failure was listed as a current diagnosis, but no plan was associated with the diagnosis. The individual had recently undergone a cardiology evaluation including diagnostic testing. The assessment and findings should have been included in the annual medical assessment. • Individual #89 received appropriate vaccinations and preventive care. Colorectal cancer screening was done with FOB. This individual was documented to have good oral hygiene on 4/5/10. The dental section of the PSP reported that periodontal disease was controlled with the aid of doxycycline. This individual was not on doxycycline at the time of the PSP. It was discontinued in November 2009 due to thrombocytopenia. Subsequent dental assessments referred to a deterioration of hygiene status to a poor rating. On	

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		5/20/10, a detailed note was included in the physician orders related to the need for good oral hygiene. On 1/30/11, the individual was documented to have uncontrolled periodontal inflammation and was scheduled for a two week desensitization. It is unclear if the dentist had knowledge of the doxycycline being discontinued in November 2009. • Individual #188 had a history of constipation, hyperlipidemia, and osteoporosis. The active problem list did not include the diagnosis of dysphagia. • Individual #96 had a diagnosis of impulse control disorder and received Haldol and trazodone. The individual received prn Bisacodyl suppositories. A modified barium swallow study was completed on 9/28/09 due to signs and symptoms of aspiration. The recommendation was to start a mechanically soft chopped diet with thin liquids by straw. This diagnosis was not noted until 3/10. This individual, therefore, did not have the proper supports implemented for someone with mild oral phase dysphagia. The PSPA dated 3/15/11 noted a new diagnosis of dysphagia. • Individual #70 had a diagnosis of Down's Syndrome, diabetes mellitus, constipation, hyperlipidemia, depression, and microcephaly. The individual received appropriate vaccinations and screenings. The annual medical assessment dated 6/15/10 noted that the individual had mildly dysmorphic features, but not the typical features of Down's Syndrome. A chromosomal analysis was done that returned normal results. Downs' precautions were removed and annual c-spine testing was discontinued. The active problem list was not updated to reflect removal of this diagnosis. The individual refused dental clinic on numerous occasions. There was no desensitization program in place. • Individual #432's active problem list was missing diagnoses of GERD and dysphagia. • Individual #252 was admitted to MSSLC with a diagnosis of hypertension and was started on lisinopril and dyazide. Clonidine was added to improve control. The initial evaluation by nephrology believed blood pressures were over-suppressed and that the high dose of clonidine should be tapered and discontinued. The nephrologist wrote a tapering protocol in the notes. Upon return to the nephrologist, it was noted "clonidine; unclear if patient is still taking .2 mg at bedtime. They were told to stop it completely by the tapering	

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		protocol by me." The PCP documented on 3/8/11 "Taper to .1 mg unclear. …Will await final signed note." Control of this individual's hypertension was critical to prevent end organ damage. There was a maternal history of end stage kidney disease requiring renal replacement therapy. o The individual's vaccination record was blank. The annual medical assessment stated vaccinations were unknown. At the time of the onsite review, four months after admission, no vaccinations had been documented in the vaccine records. o The active problem list did not include the diagnoses of metabolic syndrome and severe vitamin D deficiency. o The order for vitamin D written on 3/4/11 listed the indication of health maintenance. The nephrology consult documented a vitamin D level of 11. o The diagnoses of hyperlipidemia and CKD were added to the Active Problem List. • Individual #197 received three medications for the treatment of constipation and also received alendronate and calcium for osteoporosis. This individual did not appear on the facility's lists of individuals with constipation and osteoporosis. The individual was admitted to the hospital in 2009 with a diagnosis of UTI and fecal impaction. The annual medical assessment completed in 8/10 documented that an EGD and colonoscopy were done in 2009 but the results of those studies were unknown and not available. • Individual #79 had multiple medical problems including seizure disorder, constipation, hyperlipidemia, osteoporosis, and GERD. The individual received total enteral nutrition. o On 11/10/10 at 5:10 am, DCS reported that the individual was vomiting. The LVN documented vital signs T 97.9, POx 96%, BP 147/92, and HR 102. A large amount of emesis that looked like formula was noted and RN was notified. The plan was to monitor for more vomiting. At 10:30 am nursing documented "vomited times 2 this morning." VS: 97.2, HR 93, RR 20, BP 134/99, POx 94%. The individual was placed on sick call. o At 10:45 am, a medical evaluation was performed and the physician documented that the abdomen was distended and the patient grimaced with percussion or palpation. The last BM was 11/10/10. Orders were written to obtain KUB, CBC, and CMP and hold feedings. o At 12:50 pm nursing documented "called to room because individual vomited." VS: BP 127/97, HR 103, and POx 93%. Noted appointment at 1:30 pm. At 1:30 pm no further vomiting. o The PCP documented at 5:00 pm that the KUB showed upper loops of bowel	

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		with dilated, likely impaction, but could not rule out obstruction. Orders were given for Fleet enema and for individual to remain NPO until bowel movement. o The enema was administered at 5:30 pm. At 6:30 pm, the PCP was notified that the individual did not have a BM. Orders were given for hospital transport, which occurred at 7:50 pm. The individual was admitted to the hospital and underwent an exploratory laparotomy for small bowel obstruction. He aspirated while hospitalized and developed pneumonia. The individual was discharged on 11/19/10. o Seizure clinic, June 2010, documented individual with intractable partial epilepsy and records reviewed "seizures fairly well controlled with Depakote and dilantin. Continue and return to clinic in one year." The PCP acknowledged consult in IPN. The individual had two seizures in 2009 and 0 in 2010 at the time of consult. This was a high risk individual who received nothing by mouth. There was no physician notification for approximately five hours. More than 12 hours lapsed before the individual was transferred to an acute care facility. By 1:00 pm, there was evidence that the vomiting had persisted and the individual was not able to receive fluids or seizure medications. • Individual #188 had multiple medical problems, including hyperlipidemia, constipation, aortic stenosis, dysphagia, and, osteoporosis. o On 9/7/10 at 9:45 am, DCS reported individual vomited. VS: BP 120/70, HR 98, RR 18, T 95.6, and POx 95% (RA). Individual was awake; alert with even respirations. The plan was to monitor for further vomiting episodes. At 11:00 am nursing documented a superficial scratch to the left foot. o On 9/8/10 at 9:15 am, psychiatry documented individual was calmer since starting Zyprexa, but tended to be awake at night and sedated during the day. On 9/8/10 at 12:00 noon, nursing documented no vomiting reported. o At 6:55 pm, nursing documented that the individual was hard to arouse and that her hands and arms were splotchy. Individual was taken to room and skin was pale, cool, and dry, with purple discoloration of all four extremities. VS: POx 88% and on 2L O2NC. The Campus RN evaluated and contacted on call MD who ordered transfer to Parkview Hospital. o On 9/8/10 at 6:30 pm (late entry), DCS reported to the nurse that the individual wasn't alert enough to eat her dinner and that she had been sleeping all day. VS: Pox 88% on RA, T 96, HR 57, RR 24, and BP 124/86. The RN was notified of changes. o On 9/10/10 at 8:30 pm (late entry from 9/8/10 at 1:00 pm), nursing	

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		documented that "PNMP monitor was around individual observing feeding." Individual was sitting up with no respiratory difficulty. Skin turgor to extremities was red and mottled and cool and dry to touch. Warm clothing and blanket were applied. No follow-up was initiated at the time "due to her skin is like that most of the time." o The individual was discharged on 10/10/10 with a diagnosis of pneumonia, respiratory failure requiring mechanical ventilation, bacterial endocarditis, acute renal failure, and failure to thrive. The physician admit note for this complicated individual was less than five lines. This individual was also at high risk due to the multiple medical issues. The individual displayed evidence of clinical deterioration several hours prior to her transfer to an acute care facility. Lethargy and skin mottling were noted earlier during the day. There was no documentation of physician notification until just prior to transfer. Upon return to the facility, the physician re-admit note failed to adequately summarize a very complicated and prolonged hospital stay. The individual required several hospitalizations since this event. **Do Not Resuscitate (DNR)** There were no individuals on campus with active DNR orders. **Seizure Management** A spreadsheet was provided containing a list of all individuals with a diagnosis of seizure disorder. The facility reported that 105 individuals were treated with AEDs for seizure disorder. Eleven individuals were reported to have intractable seizure disorder and no individuals had a vagal nerve stimulator (VNS) at the time of the onsite review. With regards to medication management, 53% of the individuals were treated with one drug, 32% with two drugs, 10% with three drugs and 3.8% with four drugs. There were no individuals receiving more than four AEDs for seizure management. Neurological services were provided off site at Scott & White. There were 87 clinic appointments from September 2010 through February 2011. Neurology clinic notes included (1) reason for appointment (2) history of present illness (3) review of systems (4) past medical history (5) medications (6) allergies (7) physical exam (7) neurologic exam, and (8) assessment and plan. In January 2011, the Neurology Physician Assistant from Scott & White met with the medical staff and visited with a couple of individuals residing in the Martin unit.	

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		Neurology Clinic Examples • Individual #455 presented to clinic for follow-up of seizure disorder. The individual had not been seen since 2009. The notes documented that the individual "showed up with no documents from Mexia State School" and this delayed the visit. When seizure records became available, it was noted that the last seizure was in October 2009. The individual was to continue Keppra and Divalproex and return in one year. • Individual #436 had a history of seizure disorder and was exhibiting behaviors suspicious for seizure activity. The differential included psychiatric behaviors. Further evaluation was needed to determine if the individual was properly controlled on AEDs. • Individual #183 was seen on clinic for follow-up. The individual was receiving tegretol and had not had a seizure in over two years. A recent EEG was normal, so the medication was tapered to extinction. The repeat EEG was normal as well. The individual reported feeling better since discontinuing tegretol. • Individual #175 was seen with a diagnosis of intractable seizure disorder. The individual received Keppra and phenobarbital. Several episodes of cluster seizure activity were documented and rectal diazepam was not administered although the kit was available. The recommendation was to increase Keppra and add a 3rd medication at the next visit if no improvement was seen. It was also recorded that rectal valium was given for cluster seizure activity. • Individual #31 was recently admitted to MSSLC and was considered to be a good candidate for VNS and was refereed to neurosurgery for evaluation. o As follow-up to this case, a scan call was conducted with the medical staff and neurology physician assistant on 2/23/11 to discuss treatment. The individual was not considered to be a surgical candidate, but VNS was considered as an alternative more aggressive treatment. This call was also beneficial in providing information to the medical staff on general effectiveness of medications in controlling seizure disorders. Additional Discussion: Although the MOSES and DISCUS tools were being completed, that information was not being utilized. Consultants should be provided this information. The case of Individual #436 highlighted the importance of having appropriate integration of neurology and psychiatry. Individual #175 did not receive rectal valium in spite of having cluster seizures. This may be due to lack of a standing order or lack of staff knowledge.	

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L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and 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.	<u>Medical Reviews</u> The state medical services coordinator completed a medical quality review during the week of 3/7/11. Twenty charts across all six primary care physicians were audited. The audit assessed compliance with 32 requirements of the Health Care Guidelines, such as: • Updating of active problem list • Timeliness and completeness of annual medical summary • Documentation of food and drug allergies • Compliance with immunization requirements • Provision of preventive series • Documentation of problems, assessments and diagnoses • Management of consultations and referrals Documents provided to the monitoring team indicated compliance of 75% or greater with all items except updating of problem lists, identification of smoking, and documentation in the IPN within 24 hours of hospital return. This audit tool will need to undergo revision to include a mix of process and outcome measures. The monitoring expects to have the opportunity to review and discuss this tool at an upcoming onsite review at one of the other SSLCs. <u>Mortality Reviews</u> Mortality Reviews were another type of case review completed by the facility. 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. There were seven deaths recorded from August 2010 to February 2011. The causes of the deaths were listed as: • Septic shock, aspiration, ARDS • Septic shock, pneumonia • Unknown • Anoxic encephalopathy due to choking • Pulmonary embolus • Pneumonia (2)	Noncompliance

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		The mortality documents for seven deaths listed in the documents section above were reviewed. The Clinical Death Review Committee and Administrative Death Review Committee meetings were conducted per state policy. The final meeting, the Administrative Death Review, was completed within 30 working days for all of the deaths reviewed. The Clinical Death Review Committee meetings were conducted via scan call. The MSSLC medical director and attending physician participated in all meetings. The state medical services coordinator participated in all but one of the meetings. Other scan call participants include the state nursing services coordinator and a medical director from a sister facility. Other local participants included the QA nurse and chief nurse executive. All of the deaths reviewed generated recommendations. <u>Mortality Review Management at MSSLC</u> The mortality review process was discussed with the medical director and chief nurse executive during the onsite review week. Additional discussion was held with the QA nurse. Information related to follow-up on implementation of recommendations was requested. Each responded that individual department heads would follow-up. No one was aware of the oversight mechanism for this process. The monitoring team specifically inquired about the recommendation from a 2010 administrative death review that stated that a corrective action plan would be put in place to ensure that recommendations generated by the Administrative Death Review Committee would be implemented. The monitoring team considered this to be of considerable importance given the fact that recent death reviews repeated problems, such as significant diagnoses being excluded form the active problem list, significant delays in implementing physician orders, failure to carry out physician orders for diagnostics, abnormal vital signs not reported to RN or MD, and untimely receipt of diagnostics. None of the persons interviewed was aware of how the recommendations were being tracked. The monitoring team recommends that senior administration (e.g., facility director) take a hands-on approach to managing the death review process at MSSLC. The CNE stated that each unit had tracking systems for labs and diagnostics. When questioned by the monitoring team on the effectiveness, the CNE responded that his managers monitored that. Another concern brought forth by the monitoring team related to the possibility that dilantin may not have been discontinued in an individual that was dilantin toxic. This concern, as stated in the nursing QA review, was based upon	

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		the fact that too little dilantin was returned to the pharmacy. It did not appear that this was investigated as a medication variance. The validity of the concern was acknowledged through a recommendation to review the process of medication "hold" orders. Other concerns included and the need for more emergency equipment, ensuring that staff were trained on the use of a VNS, notification of MD when an individual refused medications, providing accurate information on required special supports to outside facilities, and training staff on the plans of individuals after moving to a new home. Moreover, there was a concern that surfaced in more than one review on the need for physicians to consider transfer to an acute care facility rather than attempt to treat acutely ill individuals on campus. Administrative death reviews conducted following the onsite review stated that the QA nurse would be responsible for tracking all recommendations generated with oversight by the facility director. A broader concern related to the mortality process is the medical review that is critical in determining the appropriateness of medical care provided. The current process did not require a written physician review of the case. There were multiple physicians who reviewed the cases through the various reports submitted (e.g., death summary, QA report, etc.). There was no physician assigned to complete a through review of all records, inclusive of the integrated record to determine if there was compliance with the standards of care of medical practice. Such a review should be comprehensive and cover all aspects of medical care. The product of such a review would be a written document that highlighted both positive and negative aspects of care and made recommendations for improvement.	
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 had not implemented a comprehensive formal medical quality program at the time of the onsite visit. The medical department was tracking data related to physician orders, and corrective actions were implemented based on the results. The infection control nurse was also addressing certain issues related to pneumonia. Information was provided to the monitoring team on hospital admissions, pneumonia rates, osteoporosis, and individuals with seizure disorder. There was no analysis of the data by the medical department for the purpose of denoting the quality of medical services. For example, the medical director should review the hospital report minimally on a monthly basis to determine the types of hospital admissions, length of stay, and hospital re-admissions rates. When an individual must return to the hospital shortly after being discharged, the facility should determine if there were any gaps in care that contributed to the readmission.	Noncompliance

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		Seizure clinic data showed that 11 individuals had intractable seizure disorder. Those data was useful and can be utilized by the medical director to ensure that those individuals are being seen by a qualified epileptologist and have at least been considered for additional non-medical management of seizure disorder. A comprehensive medical quality program will first require that the clinical guidelines be developed because these define the expectations	
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 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.	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. Also, DADS Policy #009: Medical Care was issued in July 2010. The medical director stated that the state office was in the process of developing clinical guidelines. Guidelines pending review and implementation included: • Aspiration pneumonia • Osteoporosis • Bowel management • Diabetes mellitus • Enteral feedings and • Seizure management	Noncompliance

Recommendations:

1. A clinical review team should review individuals with multiple hospital admissions and problems, such as recurrent pneumonia with the PSP to ensure that care is appropriate and seamless. This is a comprehensive review that includes all relevant data and may assist the PSP in connecting the dots and finding gaps in care.

2. Consideration should be given to revising the preventive care flow sheets to include key immunizations such as influenza, pneumococcal, Td, varicella, and hepatitis. The varicella and hepatitis components should include documentation of immunity. Given the low rate of administration of the varicella vaccination, the medical director should assess the need to alter this practice.

3. Mortality Reviews should include a detailed review of medical care completed by a physician. If an external physician cannot perform this task, the medical director should complete the review.

4. A mortality recommendations log should be maintained by the facility. The log should include the recommendations generated by the

administrative death review, the action steps to be taken, responsible parties, and timelines. This log should be reviewed with the facility administrator, medical director, CNE, and QA director on a regular basis.

5. The monitoring team recommends that senior administration (e.g., facility director) take a hands-on approach to managing the death review process at MSSLC.

6. The medical director should maintain a database of information related to preventive care such as colonoscopies, cervical cancer screening, breast cancer screening, prostate cancer screening, and bone mineral density. That data should be reviewed regularly to ensure that preventive protocols are up to date. The medical director should also examine the risk benefit analysis of those individuals who have had preventive care and cancer screenings deferred and/or discontinued.

7. The facility needs a comprehensive seizure management program. Staff should receive annual training on seizure management and those persons likely to encounter individuals with a VNS should receive regular competency based training.

8. The medical director should ensure that every individual with a history of seizure disorder have a written plan and set of orders for seizure management. Those individuals identified as having intractable seizure disorder should be given priority for assessment by an epileptologist.

9. A clinic template for neurology clinic should be developed. Clinic notes should address relevant issues including medication review, laboratory review, seizure control, previous trials of medications, side effect monitoring tool results, and adverse drug reactions. The rationale for polypharmacy should be included in the notes as well as the rationale for continued use of AEDs in individuals who have been seizure free for five years or more.

10. The facility should consider reorganizing the structure of the current annual medical assessment so that the document is more useful and provides better information to the users.

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 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 Employee Records for Christa Cobb, Cara Sturdivant, and Shirley Greeling o Corrective Action Plan 2/25/11, as requested by DADS

	o PETII Meeting Minutes (past six months) o Campus RNs Schedule and Attendance Log (past three months) o List of names of current Home Managers and name of home(s) that they are assigned o Individual Training Records for current Home Managers (past 6 months) o Shelly Fedro's course outline for 5-Day Nurse Training Course o Letter of Expectations from CNE to Respiratory Therapist o Infection Control Meeting Minutes (2/28/11) o Infection data by diagnosis by home (past 6 months) o 24 Hour Shift Reports for all units (2/1/11 – 3/16/11) o List of individuals enrolled in SAM/HIP, including the date of their enrollment o Do Not Crush List (most current, up-to-date list) o Wound Care Protocol o Wound Care Flow Sheet o Nursing Department's Plans of Correction related to death reviews (past 6 months) o Minutes from 3/15/11 Specialty and Nurse Manager RN Meeting o Records of: • Individual #505, Individual #293, Individual #567, Individual #17, Individual #528, Individual #266, Individual #432, Individual #525, Individual #444, Individual #154, Individual #151, Individual #72, Individual #285, Individual #220, Individual #542, Individual #143, Individual #406, Individual #202, Individual #549, Individual #428, Individual #51, Individual #543, Individual #98, Individual #181, Individual #126, Individual #538, Individual #79, Individual #327, Individual #120, and Individual #252 <u>Interviews and Meetings Held</u>: o Dr. William Lowry, Facility Director, and Brenda Shoemake, Assistant Director of Programs (3/14/11) o Specialty Nurse Manager Meeting (3/15/11) o Chief Nurse Executive, Norris Buchmeyer o Nursing Operations Officer, Christine Dalecki 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 Nurse Manager, Whiterock, Lyn Coleman o Home Managers: Queen Tatum, Sandra Brice, Brenda Kirven, Jennifer Stone, Mary Henderson, Sherry Mims, Lloyd Gillespie, and Regina Bedford o M5 Direct Care Staff Member, Mr. Cotton o B6 Unit Charge, Brenda Mora o Other SAM/HIP Staff: Sabina Carter, LVN and Adela Taylor

	Observations Conducted: o Medication Administration (Martin 5, Martin 6, Martin 8, Shamrock 1, Shamrock 2, Barnett 3, and Whiterock 8) o Enteral Feeding (Martin 5) o Enteral Administration of Medications (Martin 5, Martin 6, and Martin 8) o Emergency Equipment (Martin 1-8, Shamrock 1, 2, Barnett 3, and Whiterock 8)
	Facility Self-Assessment: The facility's self-assessment, its POI, for section M indicated that sections M2, M5, and M6 were in substantial compliance with provisions of the Settlement Agreement. The "Comments/Status" column for the majority of the items/action steps in the facility's POI almost exclusively referenced lists of discrete changes in nursing staff members and "topics" and "dates" of training session conducted since the prior monitoring review. In addition, some, albeit limited, descriptions of specific steps taken by the facility to achieve compliance with the provisions of Section M of the Settlement Agreement were provided. The common themes across specific actions taken by the facility to achieve compliance were steps toward (1) further identifying, refining, and focusing activities to educate staff members and correct problems, (2) revising old and creating new monitoring tools, and 3) as reported by the CNE, "…microscopically reviewing data/results of monitoring activities in minute detail." In the three sections of the facility's POI where "substantial compliance" was reported, there were anecdotal reports that "adverse data" findings obtained by the facility that pertained to self-identified practice deficiencies were significantly less than the data findings that indicated the facility's 100% compliance. In addition, the facility also reported that the results of their self-assessments revealed "…many times [the data analysis showed] that it is one aspect that only involved one nurse…" The facility's POI, however, did not reveal that oftentimes the conclusions reached by the facility were based upon results obtained from reviews of samples of individuals that fell far short of the sample sizes recommended by the facility's QA Department to ensure valid and reliable monitoring and measuring of performance and compliance with standards of care and provisions of the Settlement Agreement. The facility's POI also failed to report that its compliance scores varied widely both within and across monitoring tools, sometimes varying from 0% compliance to 100% compliance with items/measures on the same monitoring tool(s) and aggregate scores of individual reviews conducted across the same homes/units. Thus, it was not surprising the monitoring team's review of these provisions was not congruent with the facility's self-assessment's findings of compliance in three major sections, M2, M5, and M6 of Section M. Of note, however, the current review did reveal evidence of substantial compliance in several actions steps related to some components of assessment and reporting protocols, integration of clinical services, management of weight issues/concerns, and infection control surveillance and monitoring.

	Summary of Monitor's Assessment: At MSSLC, the members of the Specialty Nurse team and the Quality Assurance Nurse were an experienced and talented group of nurses. They were, by all observations, a team of nurses capable of helping the facility achieve compliance with provisions of the Settlement Agreement and ensuring that nursing care delivered at the facility would comport with nursing practices and standards that promote quality care. In addition, since the prior monitoring review, the Nursing Department had undergone positive changes in staff members who occupied positions of leadership within the Department. Also, a number of policies and processes were reviewed and revised as part of the Nursing Department's focus on compliance with the provisions of Section M of the Settlement Agreement. Done in accordance with standards and expectations, MSSLC's processes of identifying, reporting, evaluating, assessing, communicating, intervening, and documenting timely responses to significant changes in individuals' health needs and risks may effectively result in proper care and treatment. But, improvements were needed in these processes and in the training/education of direct caregivers 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, other reports, and meeting minutes, however, 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. Current annual and/or quarterly nursing assessments were not present in five of the 30 records reviewed, and in the vast majority of 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 nursing diagnoses drawn from the assessments and the plans developed from the diagnoses did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. At MSSLC, several nursing assessment and reporting protocols were in place, however, the presence of these protocols was not sufficient to ensure that the health status of the individuals at MSSLC was consistently addressed. In addition, some processes had been only recently developed or reinstated and were still being reviewed, revised, and finalized. Thus, the anticipated positive outcomes for individuals due to the implementation of these protocols were not evident in the records reviewed. At the time of the monitoring review, MSSLC had recently begun its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the PSP process. According to interviews with members of the Specialty Nurse team, all individuals will be captured by the new system of risk assessment by 4/1/11. This was reassuring since the majority of the 30 sample individuals' assignments of their level of risk had not been reviewed since August 2010 - December 2010, and many

	had not received a review of their risk across all of the identified areas of risk. The administration of medication and the management of the medication administration system at MSSLC had undergone several changes since the prior monitoring review. As indicated in more detail below, additional work still needed to be done in the areas of 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 NCPs [health management and/or nursing care 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, 16 individuals' homes were visited and 30 individuals' records were reviewed. The facility should be commended for its recent reorganization of all individuals' records into a unified record with master records and individual notebooks. Although records were organized, and nurses' notes were usually in the SOAP (Subjective and Objective (data), Analysis, and Plan) format, there were many occasions when nurses' names credentials were illegible, some nurses notes were not signed, and errors and/or incorrect entries, especially time/date, were written over and not properly designated as an erroneous entry. At MSSLC, in order to ensure timely nursing assessment, identification, notification, intervention, and documentation of significant changes in individuals' health care status the following must occur: 1. Direct care staff members promptly identify and report a problem to the LVN, 2. The LVNs promptly respond to the direct care staff member's report and review the individual and situation, 3. The LVNs report his or her findings to the RNs in a timely manner, 4. The RNs promptly respond to the LVNs' reports and conduct a complete face-to-face assessment of the individual, and 5. RNs' assessment clarify the problem and result in a nursing diagnosis, and 6. RNs develop an appropriate plan (e.g., continue monitoring, put on "sick call," transfer to emergency medical care facility) based upon a complete and comprehensive assessment. Breakdown in this process, at any point, had both an actual and potential risk of negative outcomes for individuals. For example, there was inconsistent evidence across the 30 individuals' reviewed that the individuals' RNs or campus RNs were notified in a timely	Noncompliance

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		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. • Of note, on 3/4/11, Individual #143's LVN noted that her stoma was red and "leaking brown liquid and pus." Notwithstanding this significant change in Individual #143's health status, Individual #143's LVN failed to report this finding to the RN for assessment and follow-up. Over the next 10 days, several LVNs noted that Individual #143's stoma was "draining brownish drainage with green/yellow drainage possible pus (sic)" and "…[she] continues to have yellow drainage." It was not until 3/14/11, when Individual #143's physician saw her in "sick call" that she was diagnosed with a skin infection and prescribed oral and topical antibiotics. Notably, the culture obtained from Individual #143's stoma was positive for MRSA (methicillin-resistant staphylococcus aureus) infection. There was also significant variation in the knowledge, understanding, and competence of home managers and direct caregivers to ensure that signs of significant changes in individuals' health status would be detected and reported to clinical professionals in a timely manner. MSSLC submitted numerous documents and reports that indicated that training, education, and dissemination of health information to the individuals' caregivers was of great importance to the facility's overall plan to achieve compliance with the provisions of the Settlement Agreement. They reported several many training and education strategies, some which were newly implemented and others, which were long-standing features of the Pre-Service Training and Competency-Based Training & Development programs. A review of the list of home managers at MSSLC, their Individual Training Records, and the lists of trainings provided to them by RN Case Managers revealed that all managers received at least annual training in a few health-related areas (e.g., Infection Control, CPR, Geriatric Issues, and Restraint); and some home managers availed themselves of opportunities to receive additional education in Human Development, Mental Disorders, and/or other courses offered by Navarro College. A closer review of these records revealed that during the two-month period of 1/1/11 through 3/1/11, RN case managers provided training to home managers on a myriad of health problems that ranged from training on custodial care matters (e.g., skin care, foot care, oral hygiene) to training on more complicated and specialized health problems (e.g., thrombocytopenia MRSA and boils, periodontal disease, seizures, diabetes, hypertension). Training and education of home managers and direct caregivers in health problems, needs, and risks was indeed desired and notable. But, when conducted in a	

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		manner that was not appropriate and/or conducive to learning, it failed to produce positive results. For example, a review of some home managers' records indicated that some RN case managers trained them on multiple, complex health problems all in the course of a couple of hours on one day. Other home managers' records indicated that RN case managers conducted almost daily training during a given week on a number of complex health problems. A review of three home managers' training records revealed the following: • Home Manager A: During the two-month period of 1/1/11 to 3/1/11, he/she received training by the RN case manager on 25 of 41 days. On one of these days, this home manager purportedly received training on Alzheimer's Disease, periodontal disease, arteriosclerosis, dependent edema, kyphoscoliosis, urinary tract infections, alteration in skin integrity, and cataracts. On another day, this home manager was purportedly trained on seizures, hypertension, +PPD, osteoporosis, tardive dyskinesia, blindness, and constipation. It was also noted that during a one-week period, this home manager received training every day. • Home Manager B: During the two-month period of 1/1/11 to 3/1/11, he/she received training by the RN case manager on 11 of 41 days. This home manager was purportedly trained on seizures and falls every day for four consecutive days, without evidence for why his particular home manager needed almost daily training on these two health problems. • Home Manager C: During the two-month period of 1/1/11 to 3/1/11, he/she received training by the RN case manager on 14 of 41 days. Again, this home manager was purportedly trained on multiple health problems that included MRSA infection, rash, conjunctivitis, wound biopsies, pneumonia, bronchitis, cellulitis, thrush, herpes, dehydration, diabetes, decubitus ulcers, and so forth. From this review, it was unclear what was learned and retained under these conditions. The findings of this review also raised serious concern over how direct caregivers at MSSLC were expected to know and understand the nature and impact of particular health problems on particular individuals and what actions/activities they were expected to have learned to implement to help ensure individuals' health, safety, and well-being during times of sickness and need. Interviews were conducted with eight of the 31 home managers at MSSLC. Four of the eight home managers interviewed were knowledgeable of many health and safety issues generally and specifically in reference to particular individuals under their care and supervision, however, despite the presence of voluminous training records and reports	

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		of training sessions held on a host of health problems, the other four home managers reported only a very limited knowledge of health problems and/or the expectations for what they, and the direct caregivers they supervised, were expected to do and/or should do to help meet individuals' health needs. Rather, as one home manager reported, "We have them [direct caregivers] sign the blue sheets." Although home managers and direct caregivers were instructed to consult the "Red Health Instruction Book" kept on the home for information regarding individuals' health problems, needs, and risks, a review of several of these books on different homes and units revealed that they were in various states of completion, and had not been maintained with current, complete, and accurate information. Done in accordance with standards and expectations, MSSLC's processes of identifying, reporting, evaluating, assessing, communicating, intervening, and documenting timely responses to significant changes in individuals' health needs and risks may effectively result in proper care and treatment. But, improvements were needed in these processes and in the training/education of direct caregivers 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 #154 was diagnosed with multiple health problems that included possible right ventricular hypertrophy. On 12/30/10, at 6:00 pm, Individual #54 "started having seizures," had a "blank stare," and was "non-responsive." A medical emergency call was not initiated. Rather, Individual #154's LVN checked her blood pressure three times because each time she checked, her diastolic blood pressure measured 100 and greater. So, Individual #154's LVN notified the Campus RN. After the notification, Individual #154's LVN waited an hour before she re-checked her blood pressure only to find that it remained significantly elevated: 159/101 and 166/101. At this time, Individual #154's LVN asked two other unit LVNs to re-check her blood pressure. They also obtained significantly elevated blood pressure measurements (170/100) and also a rapid heart rate (103 – 107 bpm). There were no assessments of Individual #154 for presence/absence of chest pain or shortness of breath. An	

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		hour and a half after the Campus RN was notified, he/she arrived on the scene and noted that Individual #154 had "No signs/symptoms of distress except for elevated BP and pulse (emphasis added)." In addition, the Campus RN indicated that Individual #154 was "Able to respond verbally in her usual manner, able to move both upper and lower extremities, and hand grips equal. PERL." The Campus RN called Individual #154's physician who ordered immediate transfer to the emergency room. There was no evidence that the significant change in Individual #154's health status, which was tantamount to a medical emergency, was accurately assessed, identified, and addressed as a medical emergency. In addition, it was unclear why Individual #154's LVN waited for an hour before he/she re-checked Individual #154's blood pressure and why the Campus RN failed to respond to the scene until almost an hour and a half later. In addition, there was no evidence that the Campus RN performed a complete assessment, including, but not limited to, obtaining vital signs. Also, it was unclear what was meant by the cryptic phrase "[she was] able to respond in her usual manner" and what impact, if any, her response had on the actions taken/not taken by her nurses. Of note, upon Individual #154's arrival to the local hospital emergency room, she was transferred to Scott & White Hospital for evaluation of acute versus chronic hydrocephalus, as evidenced by increased intracranial pressure. • Individual #220 was a 40-year-old woman diagnosed with multiple gastrointestinal problems. She was diagnosed with GERD, chronic constipation, multiple large-mouth diverticula, and bleeding internal hemorrhoids. On 3/9/11, Individual #220 underwent a hemorrrhoidectomy to control the rectal bleeding from her hemorrhoids. Notwithstanding the well-documented pain management issues related to hemorrhoidectomies, Individual #220 was not provided pain medication until almost 24 hours after her surgery when she was found crying and with a heart rate of 124 beats per minute. Although this surgical procedure represented a significant change in Individual #220's health status, over the next 72 hours, there was no evidence of effective pain management. Rather, Individual #220 received a total of five doses of pain medication during the period of 3/10 – 3/13/10 and only after she was found "grimacing in pain" and "crying." In addition, there was no evidence that her nurses applied ice packs to her anal area to reduce pain and swelling and/or ensured that she received frequent soaks in warm water to help reduce pain and swelling. • On 10/31/10, Individual #528's direct caregiver reported to the LVN that she had "black in her colostomy bag." Individual #528's LVN noted that there was black, tarry stool in her colostomy bag, and the stool tested positive for the presence of blood. According to Individual #528's LVN, she sent the positive test results to Individual #528's RN and was "awaiting results (sic)." There was no	

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		evidence of follow-up to this significant change in Individual #528's health status. • On 1/12/11, Individual #432 was diagnosed with oral thrush. Related to her advanced age of 87 years and weakened immune system she failed to improve after receiving initial treatment with Nystatin, an antifungal medication. Thus, on 2/3/11, her physician prescribed Decadron, Kenalog, and intramuscular injection of prednisone, which was treatment that was usually reserved for complicated cases and/or if the infection has spread. Despite the significant change in Individual #432's health, there was no evidence of at least daily nursing assessment to evaluate Individual #432's response to treatment and monitor her recovery until resolution of her infection. • On 2/16/11, Individual #432 was hospitalized for treatment of a urinary tract infection, hypokalemia, and dehydration. There was no evidence that the facility's Hospital Liaison regularly monitored Individual #432 during her hospitalization and no evidence of any contact with Individual #432's external caregivers during the five-day period of 2/18/11 - 2/22/11, which was her date of discharge from the hospital. • Individual #505 was scored at high risk for aspiration and choking. During his 12/30/10 dental examination, his dentist reported to his direct caregiver that Individual #505 had poor oral hygiene with "food from his evening meal still in his mouth [at 10:30 am the next morning]." There was no evidence that Individual #505's nurses performed regular follow-up assessments and/or monitoring of Individual #505's oral health status to address this negative health outcome and reduce his risk of aspiration of bacteria due to poor oral hygiene. • Individual #202 was a 60-year-old man diagnosed with heart disease and AICD (automated implantable cardioverter-defibrillator), anemia, dementia, GERD, and status-post renal cell carcinoma with radical nephrectomy. On 2/15/11, Individual #202 was diagnosed with a urinary tract infection and prescribed antibiotic twice a day for seven days. Despite Individual #202's significant change in health status, his high cardiac and medical risks, his recent radical nephrectomy, and his diagnosis of a Strep B urinary tract infection, which can cause serious illness including death in the elderly and individuals with compromised immune systems, there was no evidence that Individual #202's nurses monitored him at least once a day for five of the seven days during the treatment of his infection. • On 2/25/11, Individual #202 was prescribed his initial dose of Zyprexa 5 mg at bedtime. On 2/28/11, it was noted that he "fell on his buttocks." The next day, it was noted that he was found "non-responsive, lethargic, and drooling." Thus, he was emergently transported to the hospital where he was treated for syncope	

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		and seizure activity. On 3/3/11, at 7:20 pm, he returned to his home and was noted to have increased arm movements. At 7:35 pm, Individual #202's RN noted Individual #202's vital signs and documented, "[He] moves all extremities well. No apparent distress. Awake and alert. No alteration in mental status. Placed on sick call for tomorrow." Although Zyprexa has documented warnings related to its use in older adults with dementia and side effects of ataxia, lethargy, drooling, seizure, and arm/leg movements, there was no evidence that Individual #202's nurses conducted a complete assessment, including but not limited to an assessment of the side effects of Individual #202's newly prescribed atypical antipsychotic medication, upon his return from the hospital. Thus, it was not until five days later, on 3/8/11, when his psychiatrist saw him that his psychotropic medication side effects were assessed, and his psychiatrist ordered tapering Individual #202's Haldol and reducing his Ativan. • Individual #538 was a 58-year-old woman diagnosed with cerebral palsy, spastic quadriplegia, osteoporosis, diabetes, GERD, dysphagia, seizure disorder, fibrocystic breast disease, and cataracts. In addition, she was nonverbal and non-ambulatory. On 1/12/11, Individual #538's physician diagnosed her with a stage II pressure ulcer between the toes of her left foot. At this time, Individual #538's physician ordered application of Duoderm dressing and a trial of Santyl ointment over the area of hypertrophic tissue. In addition, Individual #538's physician recommended, "Close follow-up" of Individual #538's pressure ulcer. Notwithstanding Individual #538's physician recommendation and her risks of non-healing/infection associated with complications of diabetes and/or untoward response to the active enzymatic effect of Santyl, there was no evidence of follow-up by Individual #538's nurses until five days later when her nurse noted, "No sign of infection, no open area." • On 2/18/11, Individual #538's nurse noted, "BM log shows no bowel movement x 3 days. Dulcolax suppository given and awaiting results." On 2/19/11, it was noted that although Individual #538 had only a small bowel movement as a result of the suppository, she would be monitored for further effect from the suppository. There was no evidence of any further monitoring or follow-up by Individual #538's nurses. • Individual #293 was a 61-year-old man who was referred to the Walking Program/Clinic for maintenance/improvement of his balance and mobility. For one month (1/20/11 – 2/23/11), Individual #293 missed his therapy either because he was "Having a behavior and refused to walk," "Did not attend therapy today per medical," or "No therapy due to cancel by medical." Not one of Individual #293's missed therapy appointments triggered a review by his nurses, and there were no nursing assessments or nurses' notes that identified Individual #293's lack of treatment and/or referenced that his nurses closely	

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		monitored his ambulation and mobility status for possible untoward outcomes due to lack of physical therapy. • Individual #293 was seen by his physician in sick call for follow-up of his bronchitis and allergic rhinitis. According to his physician's note, Individual #293 "…sits and sleeps with fan directly on him. The fan contains copious amounts of dust and this provider considers if patient's respiratory mucosa is experiencing the inflammation currently visualized on exam. Will request that patient's fan is cleaned from dust and will see if this helps with his clinical progress." Although Individual #293's physician identified environmental factors associated with the significant change in his respiratory status, there was no evidence that Individual #293's nurses conducted any follow-up to his physician's findings/recommendations. • Individual #252 was newly admitted to MSSLC from the Dallas County Jail. He was admitted with diagnoses of severe hypertension, dyslipidemia, chronic kidney disease stage II, morbid obesity, and obstructive sleep apnea. On the day of his admission, his blood pressure measured 184/126. Individual #252 was transferred to the emergency room and his medications were changed to address his hypertension. On 11/30/10, Individual #252's medications were changed to manage his hypertension yet again. Nonetheless, there were no nursing assessments of Individual #252's response to treatment from 11/30/10 until after 12/8/10, when he was evaluated by his primary physician, who recommended additional cardiac work-up and evaluation of his hypertension. • Individual #266 was a 58-year-old woman who had multiple health problems that included osteoporosis, fixed ankle joints, and a fractured right hand. On 1/15/11, at 2:45 pm, Individual #266's direct caregivers notified her nurse that after Individual #266's bath, when she was turned over on the bath table, she began flinching and flailing her arms and "guarding her right hip." At this time, Individual #266's LVN noted, "Campus RN called to assess." An hour later, Individual #266, who was apparently still waiting on the bath table for the Campus RN to arrive was "…moved via Hoyer lift to her chair awaiting the Campus RN (emphasis added)." According to Individual #266's LVN, "[She] exhibited some reaction (sic) when being transferred." Ten minutes later, the Campus RN and Individual #266's physician arrived, evaluated her, and sent her to the emergency room. Initially, it was suspected that Individual #266 had fractured her hip, but there was no explanation for why the emergency response team was not called. In addition, there was no justification provided for the delay in the Campus RN's evaluation of Individual #266's possible serious injury; no rationale for having moved her without immobilization to prevent further injury; no explanation for why, once moved, she was put in a chair; and no evidence that ice was applied to promote comfort and/or reduce swelling.	

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		• On 1/15/11, at 8:50 pm, Individual #266 returned to MSSLC with a diagnosis of a plateau fracture of her right tibia (shinbone) with a splint and knee immobilizer on her right leg. At 11:25 pm, Individual #266's was assessed by her RN, who noted the position of her right leg, condition of her skin, nature of her respirations, presences of pedal pulses, and concluded that her "vital signs WNL" and with her "usual behavior." At this time, Individual #266 was "placed on RN follow-up." Notwithstanding the significant change in Individual #266's health status, there was no evidence that a nursing assessment was documented upon her return from the hospital and no evidence that her direct caregivers were provided with adequate and appropriate instructions regarding her special needs. In addition, although she was "placed on RN follow-up," she was not seen or evaluated again by her RN until over 12 hours later when her physician saw her in sick call. At this time, Individual #266's physician evaluated her leg fracture, and he also identified that Individual #266's stoma had green drainage, and it was infected. Individual #266's physician ordered continued immobilization of her right leg, antibiotics, and a wound culture. (Note: Individual #266's wound culture was positive for MRSA infection.) • Individual #444 was a 47-year-old woman diagnosed with multiple health problems that included constipation, and she was prescribed medications with the side effect of constipation. On 12/10/10, Individual #444's nurse noted that she had not moved her bowels in four days. At this time, her nurse performed a rectal exam and noted, "Formed stool felt." Individual #444 was given a Dulcolax suppository and results were "pending." There was no evidence of follow-up to this significant change in Individual #444's condition. Similarly, on 2/6/11, Individual #444's nurse noted that she had not had a bowel movement in five days. At this time, her nurse did not perform an assessment. But, he/she did administer a Dulcolax suppository, which produced results. • Individual #285 was diagnosed with dysphagia and GERD, and he received enteral nutrition via gastrostomy tube. On 3/5/11, at 11:55 pm, Individual #285's RN was called to his room by his direct caregivers who reported that he had vomited some of his formula. Individual #285's RN obtained his vital signs and noted a pulse rate of 109 and respiratory rate of 24. In addition, his RN noted that Individual #285's abdomen was "hard" and he had expiratory wheezing. Despite these significant changes in Individual #285's health status, his nurse failed to perform a complete assessment, including but not limited to an assessment of his respiratory status including lung sounds, examination and analysis of his relevant health data including bowel log, intake/output, prior measures of residual, prior measures of his vital signs, etc. In addition, although his RN noted that she "put [Individual #285] on follow-up" and recommended "monitor for N/V, abdominal distention, SOB, nasal drainage, and fever," the RN	

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		failed to identify and address important clinical indicators of his significant health risks - elevated pulse and respiratory rates, "hard" abdomen, and wheezing, and he/she failed to conduct a follow-up assessment. Approximately 12 hours later, Individual #285's LVN noted that this abdomen was "firm." Again, there was no examination or analysis of Individual #285's health data, including but not limited to his bowel log, intake/output data, residual log, etc. Rather, Individual #285's LVN concluded, "Continue to monitor." • During Individual #51's quarterly nursing assessment, her RN case manager noted two alterations in Individual #51's skin integrity – an avulsed left great toenail at the site of her previous paronychia infection and a 3.5 cm pustule on the back of her right thigh. According to Individual #51's RN, her LVN was informed of the alteration in her skin integrity, and she was placed on follow-up. There was no evidence of at least daily assessment and/or follow-up until her alteration in skin integrity was resolved without complication. • Individual #51 has engaged in multiple episodes of attacking and biting peers and has had many self-inflicted bite wounds. Although there was evidence that after at least one of these "attacks" (i.e., when Individual #51 attacked and bit several peers), a PSPA meeting was held to discuss Individual #51's level of supervision, there was no evidence of that the risks of infection and transmission of disease were identified and addressed. <u>Regarding numerous individuals</u> A clear-cut example of an opportunity for nurses to help ensure that significant changes in individuals' health were quickly identified, their physicians were promptly notified, and appropriate care was delivered was within the realm of their role and responsibility to ensure that staff members adequately and appropriately respond to actual medical emergencies vis a vis mock medical emergency drills. A review of the Medical Emergency Drill Checklists for January 2011 revealed that a total of 24 drills were conducted. At least seven of the 24 drill checklists indicated serious problems with staff members' response and/or failure to respond to the drills. None of the drill checklists referenced recommendations or corrective actions to address problems identified during the drills. In addition, the facility staff members who conducted the drills documented that some staff members "went into their offices and stayed there until the drill was over," some staff members stepped over and around the felled mannequin, some staff members failed to call the emergency 1333 number, some staff members failed to bring the AED to the scene, and other failed to correctly deliver chest compressions. Many of the other 17 drills did not "Fail" per se, but nonetheless, the anecdotal reports and findings related to these drills raised serious concern over the	

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		ability of the facility to ensure the health and safety of the individuals. Of note, there was no evidence in any of the nursing reports, meetings, minutes, etc. that indicated that the Nursing Department had identified and/or addressed these serious problems. The monitoring team immediately reported these findings and shared its concerns with the facility leadership/administration staff members who quickly responded and convened an emergency meeting of facility management staff members to address these problems. In addition, four Continuing Training and Development staff members, who were certified to conduct emergency drills and staff training, were added to the pool of trainers, an ad hoc committee formed to address these problems and concerns met twice, a plan was made to review all incident reports that involved CPR for potential problems related to staff members' performance in this area, the QAQI Council added a review of the use of CPR and success rate of Medical Emergency Drills to their standing agenda, and CPR instructions were laminated and added to all staff members' badges.	
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 five of the 30 records reviewed. The monitoring team reported this finding to the facility managers, 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 27 of the 30 records reviewed. Of the 30 records reviewed, 25 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 implemented in a facility, such as MSSLC, is the nursing assessment. According to the 12/1/10 Nursing Services Policy in effect at the facility, nursing assessments must be completed at a minimum upon admission, quarterly, and annually. In addition, the nursing assessment, which is an ongoing and continuous process of collecting, evaluating, and communicating data and information regarding each and every individual's needs, must also reference restorative and habilitative needs. 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. As noted during the prior monitoring review, at MSSLC, the nursing assessment was of even greater significance 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." Also noted during the prior	Noncompliance

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		monitoring review, 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 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. Also at MSSLC, in addition to the annual and quarterly comprehensive nursing assessments, nurses are required to complete a four-page Nursing Admission Summary of individuals who are admitted to the facility and, when applicable, upon discharge from the hospital and readmission to the facility. Properly completed, the comprehensive nursing assessment forms and the nursing summary assessments 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 #51 was a 30-year-old woman who was diagnosed with seizure disorder, hyperlipidemia, obesity, constipation, myopia/astigmatism, and onychomycosis. Individual #51's nursing assessments provided a comprehensive review of her current active diagnoses and her health and behavioral challenges. The nursing assessments also generated nursing diagnoses that provided an adequate basis for selection of interventions to help Individual #51 achieve her desired health outcomes. Notwithstanding the presence and use of these forms, in 25 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.	

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		Also, of the 30 records reviewed, eight were records of individuals who were hospitalized during the period of 11/1/10 – 3/17/11. None of the eight individuals' Nursing Admission Summaries were complete. All had one or more significant portions of the admission assessment that were blank. Other examples are given below: <u>Regarding specific individuals</u> • Individual #444 was diagnosed with Down's Syndrome, seizure disorder, GERD, sinus bradycardia, osteoporosis, scoliosis, fibrocystic breast disease, and seborrheic dermatitis. In addition, she was nonverbal, non-ambulatory, and suffered recurrent macerated erythematous rash in her peri-anal area. During the period of her 11/3/10-2/9/11 quarterly nursing assessment, she suffered a recurrence of her skin rash on her legs, thighs, arms, and under her breasts; she was diagnosed with conjunctivitis; she suffered several episodes of constipation, and went long periods of time without bowel movements (four to five days); she had a significant change in her weight and nutrition status and hypoalbuminemia; and she was hospitalized with bilateral aspiration pneumonia, atelectasis, sepsis, and respiratory failure. Notwithstanding these significant health problems, needs, and risks, Individual #444's quarterly nursing assessment inaccurately portrayed her health status and needs during the assessment period. For example, Individual #444's nursing assessment indicated that her constipation was "well controlled," she had "no abnormal" blood tests," she "tolerated her meals well," she had only "occasional skin problems [and] no concerns at present with her skin." In addition, the assessment of the effectiveness of Individual #444's medications and treatments were limited to uninformative one word phrases – "Good," "Effective," and "Controlled" – and, the nursing summary section of the assessment failed to provide a complete recapitulation of the negative health events suffered by Individual #444 during the prior quarter. • Individual #181 was a 38-year-old man diagnosed with mild mental retardation, schizophrenia, antisocial personality disorder, depression, anxiety, obesity, diabetes, hyperlipidemia, hypertension, constipation, and status-post left orchiectomy. Individual #181 also smoked cigarettes and chewed tobacco. Over the past several months, Individual #181's blood glucose levels widely fluctuated, and his HgbA1c increased from 9.0% to 12.7%. In addition, he was hospitalized for two weeks as a result of his uncontrolled diabetes. He also developed swelling of his left forearm, which was evaluated by his physician for the presence of infection versus injury. Despite Individual #181's many serious and high-risk health problems, there was no current quarterly nursing	

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		assessment completed by his nurses. The most current nursing assessment was completed in June 2010, and it no longer accurately portrayed his health status and needs. Notably, Individual #181's nurses documented nothing in his IPNs that approximated an assessment of his complex health needs and risks. Rather, for weeks at a time, his nurses' notes referenced nothing more than his blood sugar level and the amount of insulin they administered. • During the period of 11/10 – 2/11, Individual #154 had multiple episodes of alteration in skin integrity – some due to self-inflicted bite wounds, others due to "multiple scratches" to her legs, shoulders, arms, forehead, and face; she fell and suffered pain, spasms, and tenderness of her thoracic and lumbar areas; she developed increased seizure activity, hypertensive episode, and increased intracranial pressure; her alkaline phosphatase and ammonia levels increased; and she developed a bladder infection. Individual #154's nurses' quarterly assessments failed to provide accurate and complete evaluations of her health status during the quarterly review periods. For example, Individual #154's 11/10-2/11 quarterly nursing assessment minimized the nature and impact of her fall. The nurse's assessment failed to indicate that Individual #154 was found lying on the bathroom floor with her wheelchair tipped over on its left side. The assessment also failed to portray the significant impact of the fall on Individual #154's health status and/or that she required emergency room evaluation and treatment to rule out a broken back and local applications of lidocaine patches for management of pain. Rather, the nurse's assessment casually noted that Individual #154 "slipped and sat on the floor." Individual #154's quarterly nursing assessment failed to provide a complete review of her labs, including, but not limited to, her elevated alkaline phosphatase and hyperammonemia. For example, Individual #154's nurse inaccurately reported that her physician "disregarded" the possible side effects of her seizure medications. In actuality, over several weeks, Individual #154's physician examined the possibility of medication-induced hyperammonemia, prescribed lactulose, and ordered repeat blood tests to evaluate the results of her medical plan of care. Also, Individual #154's quarterly nursing assessment failed to provide an evaluation of the alteration in her skin integrity and abnormalities of her lower extremities. • Individual #79 was a 37-year-old man who was diagnosed with seizure disorder, osteoporosis, GERD, hyperlipidemia, spastic quadriplegia, scoliosis, constipation, hyperopia, periodontitis, and acne. His quarterly nursing assessments noted the effectiveness of his medications and treatments as "Good," and failed to provide an evaluation of their effectiveness beyond this one-word phrase. In addition, his most recent quarterly nursing assessment inaccurately indicated that he had "No noted [gastrointestinal] problems/deficits…," "No noted [enteral feeding]	

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		problems/deficits…," and that he was "Medically stable." Of note, during the most recent quarterly review period of 11/5/10 – 2/5/11, Individual #79 was hospitalized with bacterial pneumonia and pleural effusion; he underwent an exploratory laparotomy due to an acute abdomen, which was distended and with diminished bowel sounds and dilated loops of bowel, and medical concern for obstruction; and he suffered increased seizure activity, urinary tract infection, clogged/dislodged feeding tube, vomiting, alteration in skin integrity, unexplained bruising under his left arm and on the left side of his abdomen, and herpes labialis. • Individual #505 was a 53-year-old man diagnosed with profound mental retardation, hyperlipidemia, onychomycosis, constipation, benign prostatic hypertrophy, and undescended left testicle. Almost one year ago, Individual #505's urologist recommended a CT scan of his abdomen in six months due to the chance that he could have a seminoma (testicular cancer). Individual #505's nursing assessment noted that he had an undescended left testicle and possible seminoma, but it failed to put forward an adequate and complete assessment of Individual #505's response to this medical problem, and there was no corresponding nursing problem/diagnosis that addressed it. Of note, time was of the essence because with early detection and treatment, seminomas are one of the most treatable/curable cancers with greater than 95% survival rate when diagnosed and treated in the early stages. • Individual #525 was a 52-year-old man diagnosed with Down's Syndrome, mild mitral valve regurgitation and aortic insufficiency, hypothyroidism, hyperlipidemia, osteoporosis, seizure disorder, GERD, bilateral cataracts, strabismus, presbyopia, and vitamin D deficiency. Individual #525's 10/13/10 – 1/13/11 quarterly nursing assessment failed to reference an assessment of his ears and his responses to his diagnoses of hypothyroidism, atlanto-axial instability, and hallus vagus and pes planus deformities. In addition, although Individual #525's nurse noted that on at least two occasions during meal monitoring evaluations that he licked his plate after eating, and, on at least one occasion, dug in the trash for food, there were no nursing follow-up assessments of these observations and/or nursing evaluations of possible health-related (versus behavioral) antecedents, such as lack of satiation, which could have affected his conduct, versus a reoccurrence of his pica behavior, which had not been observed/recorded for over four years. • Individual #98 was a 45-year-old man who was diagnosed with psychosis, anti-personality disorder, GERD, mild EPS, metastatic squamous cell carcinoma of the face/neck, vision impairment, nicotine addiction, and insomnia. Over the past year, he underwent dissection of a tumor, chemotherapy, and radiation. Notwithstanding Individual #98's health problems, needs, and risks, his 10/10 –	

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		1/11 comprehensive nursing assessment failed to reference a review of his abnormal lab results, especially this abnormal white blood cell count, and risks related to his immuno-compromised status. In addition, his nursing assessment failed to reference his nausea, vomiting, and constipation, and sections of his assessment that pertained to the stage of his cancer, number of cigarettes he smoked, oral hygiene per his dentist, assessment of his throat, behaviors (especially aggressive and self-injurious), and immunization status were blank. • Individual #327 was a 64-year-old man diagnosed with profound mental retardation, impulse control disorder, dysphagia, constipation, periodontal disease. Some months ago, Individual #327 was hospitalized with a gastrointestinal bleed. He developed multiple system complications and required intensive care, which included tracheostomy, respirator, and total parenteral nutrition. On 2/18/11, he was reportedly transferred from the hospital to the Temple Living Center West for 60 days. According to Individual #327's nurse, he/she was "Unable to complete any [quarterly] assessment due to him not being here to assess. Upon readmission to MSSLC a complete assessment will be done." Thus, despite the role and responsibility of his RN case manager to ensure that his routine, preventive, emergency, restorative, rehabilitative nursing care was consistently delivered within accepted nursing standards of care, there were no nursing summaries of Individual #327's course of hospitalization, the treatment provided, his response to care and treatment, his progress/lack of progress toward discharge criteria, the plan for his discharge, and/or the health outcomes/goals set for him to achieve during his rehabilitation at the Temple Living Center to enable him to return to his home. Of note, the Hospital Liaison's periodic assessments of Individual #327 during his hospitalization failed to provide information and/or explanation for why he required "temporary placement at an alternate facility." These reports also failed to describe what treatment(s) Individual #327 was expected to receive and what health outcomes he was expected to achieve during his "temporary placement" to enable him to return to his home. • Two days after Individual #266's 10/13/10 – 1/13/11 quarterly nursing assessment, she suffered a fractured right tibia. Over the next month, she experienced significant changes in her health status. She suffered pain that required narcotics; her immobility increased such that in addition to the cast she had on her right hand, she required immobilization of her right leg; she developed a pressure sore on her right heel; she suffered infections of her respiratory tract and stoma; she required changes in her enteral nutrition due to increased nutritional requirements for healing; and she developed gastrointestinal upsets related to the changes in her medications and enteral formula. Despite these significant changes in her health status and functioning,	

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		there were no complete nursing assessments conducted after the above-referenced 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. • Individual #285's quarterly nursing assessments failed to reference an adequate review of his response to his medications and treatments. The assessments also indicated that the results of his nurses' meal monitoring activities were limited to one word - "Satisfactory." Absent any context, this provided little to no information and no evaluation of Individual #285's tolerance/intolerance of his enteral nutrition regimen. Individual #285's nursing assessments also inaccurately indicated that he had "no [skin] problems/deficits." During the most recent quarterly review period, Individual #285 suffered a fungal infection of his groin and skin breakdown of his gluteal cleft. These alterations in skin integrity persisted for several weeks and required medical intervention. Also, Individual #285's nursing assessments failed to reference that he had both blindness of his left eye and a cataract of his right eye. This oversight was notable as the combination of vision impairments was significant and especially relevant to his fall risk assessment. • Individual #143 was a woman diagnosed with profound mental retardation, uninhibited self-injurious behavior, impulse control disorder, seizure disorder, constipation, GERD, dysphagia, vitamin D deficiency, chronic leukopenia, cholelithiasis, and macular degeneration. According to Individual #143's quarterly nursing assessment, during the quarterly review period, Individual #143 was recovering from her recent hospitalization with constipation and acute pancreatitis. Individual #143's nursing assessment indicated that the effectiveness of all of her medications and treatments (including daily doses of polyethylene glycol to address constipation) were "Good." Notwithstanding the purported "good" results of Individual #143's medication to manage her constipation, her nurse's assessment also noted that Individual #143 received 36 PRN Fleet enemas in 12 weeks. A review of Individual #143's IPNs revealed that she had indeed received Fleet enemas multiple times a week during the assessment period. It was of great concern, however, that on many of the days when she received Fleet enemas, purportedly because she had not moved her bowels in 24 hours, her record likewise indicated that she had large bowel movements. There was no evidence in Individual #143's nursing assessments of a thoughtful, comprehensive evaluation of the frequent use of Fleet enemas, including, but not limited to, its potential to cause rectal irritation, abdominal discomfort, fluid/electrolyte imbalance, dehydration, and kidney damage. In addition, there was no evidence that Individual #143's nurses had identified the frequent use of Fleet enemas as a health risk and/or brought this issue to the	

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		attention of Individual #143's physician for his/her review. <u>Regarding numerous individuals</u> • Most of the individuals' nursing assessments failed to properly document an evaluation of the effectiveness of the individuals' medications and treatments. • Many of the individuals' chronic conditions, usually constipation, incontinence, hyperlipidemia, osteoporosis, 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. • Several individuals who received multiple administrations of PRN suppositories and/or enemas a week in order to have a bowel movement had nursing assessments that erroneously indicated that their daily oral/enteral laxatives were "effective" in managing their constipation. • There was no evidence that individuals with impaired vision, who were prescribed glasses by their ophthalmologists, received their glasses and/or were encouraged and supported to wear their glasses. In the 30 records reviewed, 11 individuals' records indicated that their ophthalmologists diagnosed them with vision impairment(s) and prescribed glasses. In the comprehensive nursing assessments, there was no evidence of any substantive nursing follow-up to the ophthalmologists' findings and recommendations save for the disclaimer, "He/She will not wear his/her glasses." According to the facility's 12/1/10 Nursing Services policy, nurses were expected to reference in their "…quarterly and annual assessments [documentation of interventions to] teach self-care to encourage activity, independence, adjustment to disabilities, and use of equipment…" • Similarly, there was no evidence that individuals whose physicians' recommended that they participate in regular physical activity/exercise programs were encouraged or supported to do so with the support of conscientious, consistent, and individualized nursing interventions and plans of care. • Six of the 30 records reviewed were of men between the ages of 19 and 40 who had serious health needs and risks, such as stage 5 chronic kidney disease, severe diabetes and insulin resistance, severe hypertension and obesity, and who were in dire need of diet and nutrition assessment, teaching, counseling, and planning. As of the review, only one of these men was receiving a structured health education program that was specifically designed and consistently implemented to address his significant diet and nutrition needs. • There was no evidence that the Respiratory Therapist (who is a member of the Nursing Department and under the supervision of the CNE) conducted timely,	

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		adequate, and appropriate assessments of individuals with acute and/or chronic respiratory problems, as required by the facility's "Duties of Respiratory Therapist at MSSLC & Utilization of the Respiratory Therapist" and in accordance with the expectations articulated by members of the Nursing Department to the Respiratory Therapist on or about November 2010-December 2010 and again on 3/16/11. • Of note, five of the 30 records reviewed were individuals who had been hospitalized with acute respiratory problems and/or individuals with chronic respiratory disease and severely compromised respiratory status. A review of their records revealed that the Respiratory Therapist visited only three of the five individuals on three or less occasions during their extensive post-hospitalization recovery periods. In addition, during these visits, there was no evidence of a complete respiratory assessment. For example, for Individual #293, during one of the Respiratory Therapist's visits, he/she obtained an incomplete set of vital signs and noted that no cough was noted and "BBS CTA at this time." On the basis of these findings, the Respiratory Therapist concluded that Individual #293's "cough and congestion seem to be resolved." Of note, over the next two weeks, Individual #293 developed a "gurgling cough and congestion" with "audible wheezing," and he was diagnosed with bronchitis. During these two-weeks, the Respiratory Therapist failed to conduct an assessment of Individual #293's significant change in respiratory status. Rather, the Respiratory Therapist visited Individual #293 over a week after he was diagnosed with bronchitis and concluded that Individual #293 indeed had an "alteration in respiratory status – bronchitis." The Respiratory Therapist did not visit Individual #293 again.	
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	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. According to the facility's 12/1/10 Nursing Services policy, 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	Noncompliance

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	implemented promptly after they are developed or revised.	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 and NCPs were in a consistent form/format. • For 28 of the 30 individuals reviewed, 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. • All of the 30 individuals reviewed had one or more NCPs, which were "mini" medical disorder, also known as "stock" care plans, which were either added to their HMPs or filed in their records in place of an HMP. 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, Impaired Dentition Plan, and Hyperlipidemia Plan. Many of these plans were not specific enough for caregivers to be able to pick it up and effectively implement individualized interventions to meet individuals' specific health care needs. The medical disorder care plans were in various states of customization/personalization, but, in general, as noted in the prior review, 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 "mini-plans" (also know as NCPs) were not revised, and they did not reflect the most current conditions and intervention strategies. • There were some, albeit inconsistent, references in the IPNs that individuals' nurses reviewed their HMPs/NCPs and either "continued" or "resolved" them. Across the 30 records reviewed, there was little evidence that individuals'	

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		nurses appropriately revised plans that they "continued," as needed and in response to individuals' progress/lack of progress toward meeting their desired health goals 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 the NCPs were not individualized. Rather, they were the same for each individual who had the plan(s), and they did not reflect the individuals' participation in their development or the formulation of their desired health outcomes. • The Nursing Assessment portions of the individuals' PSPs were completely uninformative. They did not provide even a brief recapitulation of the individuals' health status over the past year. In addition, usually the identical health objective and interventions were referenced for everyone – prevention of dehydration and adequate elimination, wear adequate protective clothing and sunscreen when outdoors, and will participate in self-administration of medication (SAM) program. Also, it was recommended that the reader "See Nursing Assessment in [individual's] chart" for more information. Examples of problems in the HMPs and "mini-plans" (NCPs) of specific individuals are presented below: • Individual #266 was a 58-year-old woman who was diagnosed with dysphagia, GERD, chronic constipation, osteoporosis, onychomycosis, and vision impairment. Individual #266's HMP failed to completed reference all of Individual #266's health needs and risks, however, it listed five goals – Individual #266 will experience no more than two seizures, no more than 12 episodes of constipation, no more than six episodes of irritation to her chest and stoma, free of fractures, and no complications related to her gastrostomy tube. First, the arbitrary health outcomes related to Individual #266's seizure disorder, constipation, and alteration in skin integrity were not desirable health outcomes, and her clinical professionals should correct it. Second, during the period of time that Individual #266's HMP was in effect, she suffered two fractures, infections of her stoma, and problems with her gastrostomy tube. There was no evidence that despite Individual #266's lack of progress toward achieving the goals of her HMP, her HMP was not revised. • Individual #244's 11/8/10 HMP and associated NCPs failed to reference any planned interventions to address her GERD, aspiration risk, constipation, anemia, alteration in respiratory status related to bilateral pneumonia, sepsis, and respiratory failure, and alteration in cardiovascular status related to sinus bradycardia. • Individual #549 was a 57-year-old man who was diagnosed with schizoaffective disorder, seizure disorder, osteoporosis, periodontal disease, GERD,	

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		diverticulosis, hemorrhoids, constipation, seborrheic dermatitis, and onychomycosis. Individual #549 was also a smoker. Over the past year, Individual #549 suffered recurrent episodes of tinea cruris due to his excessively frequent masturbation. In addition, he also suffered seizures, sustained injuries due to falls and fights with peers, and gained approximately 20 pounds, which was an undesirable, unplanned weight gain. Individual #549's PSPA met frequently to discuss his level of supervision and behavior challenges. They also met on 2/25/11 to discus his weight (gain) and nursing care plans for altered skin integrity. There was, however, no evidence that Individual #549's PSPA discussed his other significant health problems or that his HMP had been duly revised to reference all of his health problems, needs, and risks. For example, as of the monitoring review, Individual #549's HMP generally referenced one of his health problems – alteration in skin integrity – and failed to reference his chronic conditions related to osteoporosis, seizure disorder, GERD, constipation, nicotine addiction, periodontal disease, and it failed to reference his more recent health concern related to weight gain. Of note, Individual #549's HMP related to alteration in skin integrity with specific references to tinea cruris failed to reference any health education/teaching to address Individual #549's need to learn adequate and appropriate genital hygiene and strategies, like appropriate hand-washing, to reduce his risk of acquiring and transmitting disease. • Individual #120 was a 69-year-old woman who was diagnosed with intermittent explosive disorder, hypothyroidism, hyperlipidemia, vision impairments, periodontal disease, osteoporosis, and onychomycosis. On 10/7/10, she suffered a lower leg fracture and underwent intermedullary nailing of her right tibia. Although her leg fracture and immobilization had a significant impact on her mobility and increased her risks related to immobility, these problems and risks were not specifically identified and addressed in her HMP or in the associated NCPs. Thus, it was not surprising that absent a specific, individualized nursing care plan to guide and direct actions and activities of caregivers to promote Individual #120's desired health outcomes, Individual #120's physical therapy assessment and rehabilitation of her right leg was delayed for almost one month. On 1/10/11, Individual #120's physician recommended "physical and occupational therapy to work with her to transition her back to walking." But, it was not until 1/31/11 that Individual #120 was evaluated by her physical therapist. Notably, her physical therapist reported that Individual #120 was "eager to walk." • Individual #428 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 #428's' 7/21/10 PSP, his HMP should address his health	

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		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, health education and teaching about his disease and prevention of transmission, including substance abuse and safe sex practices. Of note, over the past six months, on at least two occasions, Individual #428's nurses noted that he returned from furlough with his HIV medications still present in the bottles. When his nurses' asked him if he forgot to take his medications, he replied, "Yes, sometimes." Notwithstanding his admission of non-adherence to treatment protocols, there was no evidence that this serious risk was identified and addressed by Individual #428's nurses. This oversight has had both actual and potential negative health outcomes for Individual #428. Of note, on 3/4/11, Individual #428's viral load, which was previously undetectable, was elevated. In addition, rather than a goal to remain "free" of complications related to his HIV, his 2/2/11 comprehensive nursing assessment indicated that his goal was to experience "less than four episodes of complications of HIV (emphasis added)." This is not a desired health outcome, and Individual #428's clinical professionals should correct it. • Individual #505 was a 53-year-old man diagnosed with benign prostatic hypertrophy, undescended left testicle and possible seminoma, hyperlipidemia, constipation, and early cataracts. All of these health problems and risks were identified in his comprehensive nursing assessment. But, the only health management/nursing care plan developed to address his health needs and risks was a two-page plan to address onychomycosis. • Individual #406 was a 34-year-old man who was diagnosed with schizoaffective disorder, antisocial personality disorder, hypertension, asthma, tinea pedis, onychomycosis, and insulin dependent diabetes mellitus with early nephropathy, neuropathy, and insulin resistance. According to Individual #406's endocrinologist, Individual #406 was noncompliant with his diet and treatment, had "severe diabetes" and "needed better renal protection." In addition, Individual #406's endocrinologist astutely noted that his greatest problems occurred on weekends when his morning blood sugar levels were greater than 200. Notwithstanding the Individual #406's high health risks related to complications of his diabetes and co-morbid conditions, at the time of the review, he did not have a HMP and/or nursing care plan to address his health problems, needs, and risks. • Individual #98 was a 45-year-old man who was diagnosed with psychosis, anti-personality disorder, GERD, mild EPS, metastatic squamous cell carcinoma of the face/neck, vision impairment, nicotine addiction, and insomnia. Over the past year, Individual #98 underwent dissection, chemotherapy, and radiation, and, as	

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		of the review, cancer-free, however, it was noted in his record that the cancer, once detected, had already spread from his lip to his neck and lymph nodes. Also, over the past year, he has made several threats to kill himself and moved from one home to another because of problems getting along with others. He had multiple PSPAs to address his level of supervision related to his psychiatric needs. Neither the PSPAs nor his HMP/NCP clearly addressed his diagnosis of metastatic cancer and his psychosocial health needs related to the diagnosis of cancer, facial disfigurement, and possible anxiety and/or fear related to death and dying. In addition, Individual #98's HMP failed to put forward specific, individualized interventions to address his nutrition and hydration (e.g., red Gatorade available at all times), risk of injury related to suicide attempts, distorted body image (e.g., regular opportunities for counseling, support group, spiritual guidance, etc.), and management of chronic (versus acute) pain (e.g., meditation, relaxation, exercise, music, etc.). • Individual #285 was a 62-year-old man diagnosed with seizure disorder, osteoporosis, dysphagia, spastic quadriplegia, GERD, constipation, periodontal disease, blindness, and Hepatitis B positive. On 2/10/11, Individual #285 had two successive seizures – one that lasted two minutes, the other lasted three minutes. He developed respiratory difficulty, a medical emergency was called, and he was administered Diastat 10 mg. According to Individual #285's records, had not had a seizure since 11/8/09. Notwithstanding this significant change in Individual #285's health status, there was no HMP and/or nursing care plan developed to address his seizure activity/disorder. • Individual #538 was a 58-year-old woman diagnosed with cerebral palsy, spastic quadriplegia, scoliosis, seizure disorder, osteoporosis, constipation, fibrocystic breast disease, diabetes mellitus, dysphagia, GERD, cataracts, onychomycosis, and bruxism. Over the past several months, Individual #538 suffered an unplanned, undesirable weight loss, a stage II decubitus between the toes of her left foot, increased seizure activity, and an ear infection. Individual #538's HMP and nursing care plans failed to reference all of her health problems, needs, and risks. There were no HMP/nursing care plans developed to address her osteoporosis, GERD, dysphagia and aspiration risk, fibrocystic breast disease, alteration in skin integrity, and high risk of osteonecrosis due to her bruxism and receipt of Fosamax.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the	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, some processes had been only recently developed or reinstated and were still being reviewed, revised, and finalized.	Noncompliance

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	health status of the individuals 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 Specialty Nurse team, which included the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison, Nurse Recruiter, and Infection Control Nurse; the Quality Assurance Nurse; the Nurse Managers; and the RN Case Managers continued to work toward meeting the provisions of the Settlement Agreement. Since the prior monitoring review, a new Nursing Operations Officer joined the team, and several changes occurred in various nursing leadership positions. Other changes also occurred within the ranks of the Nursing Department. The use of agency nurses was significantly reduced from an average of 25 FTEs to nine FTEs (as of 2/16/11) to approximately 12.5 FTEs per week (as of 3/16/11); and several RN positions were converted to LVN positions. Notwithstanding the converted RN positions, at the time of the monitoring review, in addition to the Specialty Registered Nurses, there were several other groups of Registered Nurses present at the facility. There were Registered Nurse Managers, Registered Nurse Case Managers, Campus Registered Nurses, Registered Nurses who assisted the physician during "sick call," and other home/unit-based Registered Nurses who were assigned various unit-/home-based nursing duties. According to the CNE, the Nursing Department was "still short-staffed" by 15 LVN positions. The CNE reported that, since the prior monitoring review, he had been instructed to reduce the use of contract agency nurses and was only permitted to use contract agency nurses up to the level of vacant positions, which were almost entirely LVN positions. So, one of the ways the CNE planned to improve staffing levels was to create more vacant LVN positions. He planned to do this by converting four vacant RN positions to LVN positions so that he could increase the number of present, on-duty staff with contract agency nurses. At first, it appeared as though these actions/activities were nothing more than taking from one and giving to another. And, it begged the question of what, if any, impact would "converting" RNs to LVNs have on the delivery of nursing care across the facility. In addition, it was unclear whether or not any analysis had been done related to these staffing decisions. According to the CNE, a "staffing needs analysis," which would clarify and inform staffing decisions, had not been done, but it was plainly needed. Nonetheless, the Nurse Recruiter continued to carefully recruit, select, train, monitor, and evaluate the contract agency nurses' performance and adherence to the facility's assessment and reporting protocols and standards of practice. If the Nurse Recruiter had	

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		any doubt or question in her mind about the character and/or competence of a contract agency nurse, she assigned the individual to the facility's "DNR" (do not return) list. In addition, the Nurse Recruiter actively sought qualified applicants to fill the vacant nursing positions. She also listened to nurses' complaints, heard their concerns, and reported issues and proposed solutions at nursing management meetings. She had also advocated for improving the working conditions at the facility, and, as a respected nurse, she regularly participated in the facility's monitoring activities and corrective actions plans to improve the delivery of nursing care. Since the prior monitoring review, the CNE and other members of the Specialty Nurse team reported improvements in several assessment and reporting protocols: (1) the quality and timeliness of quarterly comprehensive nursing assessments had improved, (2) initial and on-going training and education of nurses had expanded, (3) medication administration errors had been identified and practice issues addressed, (4) infection control assessments and reporting protocols had improved the timely identification of contagion problems and implementation of preventative plans the reduce the spread of disease, (5) "Guidelines for Prevention and Treatment of Altered Skin Integrity (3/16/11)" were recently developed, (6) increased support to the Hospital Liaison had improved coverage of individuals in the hospital during her leave time, weekends, and holidays, and (7) the 24-hour Shift Report was recently reinstated. One of the steps taken by the facility to achieve improvement in the assessment component of the nursing process was the expansion of initial and on-going training and education of its nurses. During the monitoring team's interview with the Nurse Educator, a newly developed, five-day, intense "On the Job Training Curriculum" was discussed. The facility's RN Assistant Nurse Educator taught the curriculum, which included training, education, and testing across many areas of nursing practice, over a five-day period. According to the Nurse Educator, this program was well received and attended. It was also reported that in the coming weeks, this program might be incorporated into a statewide nurse education initiative, which is currently in the planning and development stages. Notwithstanding these positive findings, as noted in Section M2, there were serious problems in the accuracy and completion of the vast majority of the assessments reviewed. The CNE also reported that since the prior monitoring review, the procedure of counting medications every shift had been implemented. According to the CNE, counting medications on hand every shift significantly improved the facility's ability to reconcile medications given/not given, enabled nurses to identify potential medication errors in a more timely way, and provided the facility with information that was valuable to the calculation and interpretation of accurate and reliable medication error rates. Thus, the	

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		CNE interpreted the recent increase in rate of medication error to be related to an increase in "reporting" errors versus problems in practice. Unfortunately, this conclusion was not verified during the monitoring team's review of medication administration (see section M6 for details). Rather, serious problems in administration of medications persisted, and the positive outcomes of the Nurse Educator's education, training, and insistence upon "strict compliance" with medication pass procedures had not yet been achieved. As noted by the CNE, the Infection Control Department has indeed "expanded its authority into all areas of the campus. Since the prior monitoring review, the Infection Control Nurse has stepped up her monitoring and surveillance of actual and potential risk of infection and continued her involvement in most aspects of nursing assessment and reporting. Wherever and whenever a need for infection control training, education, and/or monitoring was identified, the Infection Control Nurse was present, able, and willing to provide advice, training, and onsite mentoring for all employees and individuals. During the Monitoring team's interview with the Infection Control Nurse, she gave numerous examples of ways in which she identified, assessed, reported, and followed-up on actual and potential risks of infection. She reviewed sick call sheets/logs, read 24-hour reports, contacted home managers, and conducted "spot checks." 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. Since the prior monitoring review, the Infection Control Nurse had further refined her Infection Control training curriculum and gathered information on individuals' immunization histories. Her plan was to make this information available electronically to clinical professionals by Summer 2011. She also published articles about important and relevant aspects of infection control and prevention in the facility's employee newsletter. 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 continued to work very closely with the Habilitation/Therapy Department, and especially with the physical therapist that was certified in wound care. She also convened skin integrity meetings	

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		twice a month. The meetings included 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. Of note, a review of the meeting minutes revealed that the "Disposition" columns were consistently blank and no recommendations and/or corrective action plans to address areas of concerns were documented. This was a significant oversight that should be addressed by the Committee. During the monitoring team's interview with the Wound Care Nurse, she reported that she was still working on a wound/skin care treatment protocol. Notwithstanding that report, on 3/16/11, the CNE reviewed and approved the "Guidelines for Prevention and Treatment of Altered Skin Integrity." This was of concern because it was not evident from a review of the past several months' Skin Integrity Committee Meeting minutes that the Committee had reviewed/approved the new guidelines for submission to the CNE. Rather, to date, the minutes of the Committee meeting consistently indicated that the "Skin Integrity Policy [was] still on hold." In addition, although the Guidelines stipulated that the Wound Care Nurse would provide consultation and evaluation of skin breakdown, the record reviews of a number of individuals with alteration in skin integrity failed to show that they received consultation, evaluation, and/or monitoring by the Wound Care Nurse, despite occasions of infection and resistance to treatment As noted in the prior monitoring review, the facility continued to support the role and function of the Hospital Liaison to improve their performance in the area of integration of clinical services. The Hospital Liaison continued to promote communication between external providers and the facility's Medical Director and physicians. She communicated her assessment of individuals' hospital care/treatment and their response to treatment via written reports, which were sent to the individuals' nurse case managers, physician, and DCS Supervisor, and were also filed in the individuals' records. As such, the Hospital Liaison has remained directly involved in the daily process of nursing assessment and reports. Notwithstanding these positive findings, a review of 30 individuals' records revealed that the IPNs of several individuals, who were hospitalized had significant periods of time, when either visits or contacts with their external providers were not made. For example, a review of Individual #327's record revealed that over half (60%) of his hospital stay had not been monitored by the Hospital Liaison. During the monitoring team's interview with the Hospital Liaison, she reported that another nurse was recently assigned to monitor individuals who were in the hospital when she was off-duty. She affirmed that this corrective action would help to address the failure to provide consistent monitoring of individuals who were hospitalized.	

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		Finally, the CNE reported that he reinstated the documentation of a 24-hour Shift Report as another step toward achieving compliance with establishing and implementing nursing assessment and reporting protocols sufficient to address the health status of the individuals served. On its face, this appeared to be a possible solution to a difficult problem – ensuring effective communication of important health information among relevant and appropriate clinical professionals, however, it was unclear why a pilot project was not considered prior to the facility-wide implementation of a fairly time-consuming process that had no track record of positive outcomes. A review of all shift reports for the period of 2/1/11 – 3/16/11 revealed that across units/homes, they were not consistently completed; the columns on the form were not used as designated; the most frequently omitted sections were the "Plan of Action," "RN Follow-Ups," "Sick Call by 10-6 RN," and "Home Charge Follow-Ups;" and they usually provided information that was limited to notices of illnesses, transfers, injuries, medications, etc. usually absent follow-up information. Although the documentation of illnesses, injuries, medications, restraints, etc. that occur during a 24-hour period was useful information, it is not a substitute for nurses' individual-specific, thorough, and complete verbal reports to oncoming nurses at change of shift. Notwithstanding all of the above-references processes, procedures, efforts and improvements, one of the most significant and persistent barriers to implementation of improved nursing assessment and reporting protocols was nursing practice. The Nurse Managers, RN Case Managers, Campus Nurses, Unit RNs and LVNs 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). The problems that had not been addressed at this level of actual nursing practice assessment and reporting, affected the facility's achievement of compliance at each and every level, and, especially as referenced above in sections M1, M2, and M3 of this report. On 1/3/11, a new Nursing Operations Officer (NOO) was hired. She stepped into her new position with many problems to fix. Although the NOO had only been working at the facility a short time, she had already established herself as a leader. In addition, she was exceedingly well organized, and whatever she did not know, she made it her business to learn. As of the review, she had already begun helping reduce unscheduled absence, completing overdue performance evaluations, investigating and addressing clinical	

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		matters that were impeding the delivery of nursing care, and helping nurse case managers success with better management of their time. Since the prior monitoring review, the Quality Assurance Nurse had continued to participate 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 her reviews were completed in a timely manner and the findings and recommendations of her reviews were important, relevant, and consistent with standards of practice. A review of the six death reviews that were completed by the Quality Assurance Nurse over the past six months, revealed patterns of problems in nursing care. For example, she often concluded with findings that record documentation, including assessments and plans, was incomplete, physicians' orders were not noted and/or implemented in a timely manner, and nursing care was not provided in accordance with standards of practice. Furthermore, the Quality Assurance Nurse put forward recommendations that, if implemented, would have helped the facility to achieve compliance with the provisions of the Settlement Agreement and Healthcare Guidelines. Of note, there was no evidence that the Nursing Department prepared comprehensive plans of correction in response to the findings and recommendations of the Quality Assurance Nurse's death reviews, save for their participation in the development of one formal corrective action plan prepared at the request of DADS. In addition, a review of the employee records of three nurses specifically referenced in the death reviews and recommended to receive disciplinary action, revealed that no such actions were planned or taken.	
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.	At the time of the monitoring review, MSSLC had recently begun its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the PSP process. MSSLC implemented the Health Risk Assessment Rating Tool as part of their efforts to consistently assess and identify each individual's level of risk (low, medium, or high) across a number of particular areas: seizures, aspiration, choking, medical, cardiac, constipation, dehydration, diabetes, GI concerns, hypothermia, osteoporosis, polypharmacy, respiratory, skin integrity, UTIs, weight, injuries, and their overall risk level. Additional rating tools were completed for risks associated with dental status. According to interviews with members of the Specialty Nurse team, all individuals will be captured by the new system of risk assessment by 4/1/11. This was reassuring since the majority of the 30 sample individuals' assignments of their level of risk had not been	Noncompliance

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		reviewed since August 2010 - December 2010, and many had not received a review of their risk across all of the identified areas of risk. All of the 30 sample individuals had multiple risks related to their health and/or behavior, and many had one or more "high" health risks. As noted in the previous reviews, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. Therefore, this provision item was rated as being in noncompliance. Of note, reviewing and revising the individual's health risk rating upon significant change in condition was not a new expectation, it had always been a requirement. Examples included the following: • Individual #543 was a 33-year-old man who was diagnosed with mild mental retardation, psychosis, depression, impulse control disorder, seizure disorder, insulin dependent diabetes mellitus, vitamin D deficiency, dyslipidemia, hypertension, and obesity. Over the past six months, Individual #543's blood glucose levels widely fluctuated, his HgbA1c significant increased from 6.7 to 10.8, and he required the addition of sliding scale insulin to control his diabetes. During the past three months, Individual #543 was hospitalized due to acute necrotizing pancreatitis with sepsis and acidosis. Despite these significant changes in Individual #543's health problems and risks, as of his 8/4/10 risk assessment, he was rated at low risk for all health indicators except for "behavior," which was scored as "medium" risk. • Individual #444 was a 47-year-old woman diagnosed with multiple health problems that included Down's Syndrome, seizure disorder, GERD, osteoporosis, constipation, and seborrheic dermatitis. Over the past three months, Individual #444 suffered bilateral pneumonia, atelectasis, thoracentesis, sepsis, hypotension, alteration in skin integrity, hypoalbuminemia, neutropenia, sinus bradycardia, and episodes of four to five days without bowel movements. Notwithstanding these significant changes in Individual #444's health status and risks, her 1/31/11 low risk ratings for cardiac, choking, circulation, constipation, fluid imbalance, and gastrointestinal were unchanged, and her medium risk ratings for aspiration, infection, respiratory, and skin were also unchanged. Of note, Individual #444 had no high health risks identified vis a vis her risk assessment. • Individual #143 was a woman diagnosed with multiple health problems that included multiple gastrointestinal problems - constipation, GERD, dysphagia, and cholelithiasis – and post-hospitalization for treatment of acute pancreatitis. According to Individual #143's quarterly nursing assessment, during the quarterly review period of 11/26/10 – 2/15/11, Individual #143 received 36	

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		PRN Fleet enemas in 12weeks. Nonetheless, Individual #143's risk ratings of "medium" and "low" risk for gastrointestinal, fluid imbalance, and other problems were unchanged.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement 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.	The administration of medication and the management of the medication administration system at MSSLC had undergone several changes since the prior monitoring review. As indicated in more detail below, additional work still needed to be done in the areas of management of the medications by the nurses and in the oversight of medication errors. Therefore, this provision item was rated as being in noncompliance. Observations of medication administration, oral and enteral, were conducted on Martin 5, Martin 6, Martin 8, Shamrock 1, Shamrock 2, Barnett 3, and Whiterock 8. Central 7, Central 8, and Whiterock 2. During four of the seven observations, nurses failed to administer medications in accordance with standards of practice. For example, during the four deficient medication passes, nurses did not check the placement of enteral tubes prior to the administration of water flushes and medications; nurses did not follow proper infection control practices and precautions to sanitize their hands between their contacts with residents and/or other soiled materials, such as dirty washcloths, towels, and adult protective garments; nurses pre-poured "stock" medications from labeled containers into unlabeled medication cups; and one of the four nurses borrowed medication from one individual to give to another. The failure of nurses to ensure proper cleanliness and adhere to standards of infection control during medication administration, put individuals, especially those who required enteral administration of medications, at unnecessary risk of harm. All of the 30 individuals reviewed had a "pre-SAM" or "SAM" (self-administration of medication) assessment and designation filed in their record. More than half 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. Individuals' pre-SAM or SAM programs, however, were not implemented during five of the seven medication passes observed by the monitoring team. During one of these five observations, it was of particular concern that an individual, who had a bulbous nose and was unable to tilt his head backward, was not provided with his appropriate adapted equipment during the administration of his medications. As a result, he attempted to drink from a cup by inhaling its contents while the liquid spilled from the bottom and sides of the cup and soaked the front of his shirt. The individual's nurse reported to the monitoring team that she did not have, and had not been provided with, the individual's adapted equipment (cup). She also reported that, given the lack of proper equipment, it had been her practice to modify a paper cup by tearing the top and side of the cup so that	Noncompliance

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		the individual could more easily drink its contents. But, recently, she was instructed not to do that anymore. Administration of medications to individuals who required adapted equipment without their equipment, as illustrated by this example, put residents at unnecessary risk of harm. According to the Chief Nurse Executive, since the prior monitoring review, there had been more changes in the processes that surrounded medication administration and review. There was a change in the lead pharmacy staff member, implementation of daily counts of medications on all homes on all units, and changes in the nature and scope of monitoring the administration and storage of medications. Notwithstanding these changes in process, as noted in MSSLC's prior monitoring reviews, 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, which were slated for repair, had not been fixed, bins were not adequate for the storage of individuals' medications, and drawers were overloaded with stock medications. Since the prior monitoring review, nurses were no longer required to count and record for every individual the number of pills on hand for each medication present in their bin(s) on every shift. Rather, they were supposed to reconcile medications once a day. Shifting corrective action from a counting exercise to a thoughtful review and explanation of the difference between medication administration records and actual medication(s) on hand reconciliation was a step in the right direction. As reported by the CNE, it was one of the only ways to make nurses ore accountable and pinpoint areas of breakdown and focus in on problems in performance. The review of 14 individuals' current MARs for the period of 3/1/11 to 3/15/11 revealed problems of omissions and/or discrepancies in the MARs of five individuals (Individual #151, Individual #528, Individual #432, Individual #220, and Individual #542) of the 14 individuals reviewed. These omissions and discrepancies included several missing entries for psychotropic, bowel, and antibiotic medication(s), vitamins/supplements, and wound and skin treatments 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 continued to identify and report essentially the same findings month after month: 1. Martin had the highest number of errors, which was probably due to the number	

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		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, and 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 were strategically planned, focused, interventions, but general strategies of training, monitoring, and re-training applied across the campus. The prior six months' meeting minutes also revealed that the committee noted an increase in reported medication errors, but continued to put forward the same recommendations, meeting after meeting, without adequate examination of the barriers to implementation and improvement. For example, from September 2010 to January 2011, problems were noted and recommendations were made to address (1) use of abbreviations on the MARs, (2) reference to parameters of monitoring and reporting on physician orders, (3) nurse managers to address identified problems during observations of passes and monitoring, and (4) distractions during medication administration. Despite these repeatedly referenced problems and related recommendations, as of the review, they had not been resolved and barriers to resolution had not been identified and addressed. Since the prior monitoring review, one notable improvement in the area of medication administration was that medication error rates were being calculated and examined and discussed at the Medication Error Review Committee and Pharmacy & Therapeutics Committee meetings. What was revealed in the computation and analysis of these error rates was that a significant number of medications had been returned to the pharmacy without explanation, plus a significant number of unexplained "shortages" of medication(s) had occurred on regular basis. Clearly, with the addition of new and clarifying information, more challenges lie ahead. However, it was of concern to the monitoring team that with the change in pharmacy leadership, it was reportedly, "Back to square one."	

Recommendations:

1. Clarify and explicitly communicate the expectation for all Registered Nurses to be visible on the homes in the locale of the individuals and their direct caregivers at different times of the day/evening every single day.

2. The NOO has asked RN Case Mangers to keep a "diary" of their daily activities. Consider extending this request to all RNs at the facility so that the RNs' time and clinical expertise may be used as effectively as possible to improve day-to-day nursing care at the facility.

3. Focus on the delivery and outcomes of nursing care, i.e., nursing operations. Consider communicating to all nurses that they are all responsible for all nursing care delivered all of the time to all individuals.

4. Consider ways to support the Infection Control Nurse's ability to conduct "real time" surveillance of implementation of standards of infection control on the homes, including areas of the home where infection risks loom large.

5. Consider treating medication administration as a "high risk medical procedure" that can only take place in the right space/environment, with the right equipment, and with the right clinical professional, i.e., the nurse who knows the medications, their side-effects, and how to administer them safely.

6. Ensure that the professionals' and non-professionals' responses and conduct during medical emergency drills meets standards of care and requirements set by facility policy and procedure.

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

8. Ensure that nursing assessments are complete and comprehensive.

9. Integrate the various mini-plans 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.

10. 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.

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

The following are offered as additional suggestions to the facility:

12. Consider conducting a review of the outcomes of the reinstatement of the 24 Hour Shift Report.

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:** Documents Reviewed: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o Texas Department of State Health Services, Medication Audit Criteria and Guidelines Revised 4/10 Texas Department of State Health Services, Drug Audit Checklist, Revised April 2010 o MSSLC Pharmacy Policy and Procedure Manual, Quarterly Drug Regimen Review, 2/14/11 o MSSLC Home Life and Training Manual, Medical Services -22, Adverse Drug Reaction Reporting, 2/17/11 o MSSLC Pharmacy Policy and Procedure Manual, Safe Medication Practices, 2/18/11 o Pharmacy and Therapeutics Committee Meeting Minutes, dated, 9/10, 10/10 o Medication Error Reduction Committee Meeting Minutes, dated 8/30/10, 9/27/10, 10/29/10, 11/29/10, 1/3/11, and 1/31/11 o Quarterly Drug Regimen Reviews for the following individuals: • Individual #104 Individual #509, Individual #374, Individual #187, Individual #56, Individual #6, Individual #375, Individual #261, Individual #238, Individual #88, Individual #367, Individual #441, Individual #37, Individual #242, Individual #539, Individual #557 Individual #303, Individual #500, Individual #533, Individual #229, Individual #525, Individual #172, Individual #228, Individual #259, Individual #464, Individual #431, Individual #131, Individual #231, Individual #341, Individual #390, Individual #181 o MOSES and DISCUS forms for the following individuals: • Individual #365, Individual #310, Individual #562, Individual #335, Individual #159, Individual #225, Individual #74, Individual #462, Individual #217, Individual #503, Individual #526, Individual #454, Individual #306, Individual #143, Individual #293, Individual #339, Individual #386, Individual #21, Individual #353, Individual #463, Individual #475, Individual #85, Individual #238, Individual #2 o Drug Utilization Evaluation Summaries: • Seroquel • Phenytoin o Review of Quarterly Drug Regimen Reviews Interviews and Meetings Held: o P. Sulisa Lo, Pharm.D, Acting Pharmacy Director o Dolores Erfe, MD, Medical Director o Ricarda Price-Burke, RPh, Pharmacist II o Norris Buchmeyer, Chief Nurse Executive o Karen Wilson RN, QA Nurse

	o Meeting with Acting Pharmacy Director, Medical Director, and Chief Nurse Executive <u>Observations Conducted</u>: o Pharmacy and Therapeutics Committee Meeting
	Facility Self-Assessment: The facility found itself in substantial compliance with Provisions N1, N2, N3, N4 and N5. It rated itself non-compliant with Provisions N6, N7, and N8. The monitoring team agrees with the finding of substantial compliance for Provision N1, N3, and N4. Provisions N6, N7, and N8 will require considerable work to meet the requirements of the Settlement Agreement. Inconsistencies found in reports and failures of the medical staff to complete documents and incorporate data into clinical practice will need to be addressed to reach substantial compliance with Provisions N2 and N5.
	Summary of Monitor's Assessment: The pharmacy department was staffed by a clinical pharmacist who served as acting pharmacy director, two registered pharmacists, and four pharmacy technicians. Significant progress was made in pharmacy services since the September 2010 onsite review. The prospective reviews of medication orders continued through the double check system. The clinical intervention log was used to document interactions between the pharmacists and physicians. Clinical intervention data was being used to improve the provision of pharmacy services and physician prescribing patterns. The leadership of the pharmacy department changed at the end of January 2011. The quality of the drug regimen reviews had improved substantially. Many of them had been typed to improve readability. Moreover, the reviews contained more robust information and routinely commented on monitoring parameters for psychotropic and AED use. Physicians were responding to recommendations made by the pharmacists and this was good to see. Tracking of physician responses had been initiated, although exactly how that information was being used was not clear. The MOSES and DISCUS tools were being completed, but work was needed in the area of making this information useful. Primary care physicians did not seem to utilize this information and none of the neurology notes reviewed captured these findings. Two drug utilization evaluations were completed, but considerable work was still needed in this area. There was no local policy to guide this process resulting in two DUEs that were presented in entirely different formats. The facility started reporting adverse drug reactions, but the system will require several changes in order to be clinically relevant. Medication variances were being reported and reviewed. Medication errors increased in part due to

	frequent counting and reconciliation. Even more concerning were the reports of hundreds of doses of medications that were retuned to the pharmacy on a monthly basis with no explanation for almost half of the returns. The ADR system, DUE system, and medication variance system appeared to be very disjointed. The connection between these systems and how they function within the medication use system was not apparent to the staff or evident in the processes. The provision of safe pharmaceutical services will require that the facility's clinical leadership have greater understanding of the medication use system and the processes that support and monitor the provision of services.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N1</td><td>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 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.</td><td>A prospective review was completed for all new orders through the WORx software program. The program checked a number of parameters, such as therapeutic duplication, drug interactions, allergies, and other issues.

The MSSLC policy Safe Medication Practices required documentation of all discussions between the pharmacist and prescribing physician on the medication order. Additionally, documentation of all clinical interventions was required in the Pharmacy Clinical Intervention Log (PCI). The clinical pharmacist reported that this process was utilized. The monitoring team requested all PCI data since the last visit.

Pharmacy Clinical Intervention Logs for October 2010, November 2010, and December 2010 were provided. A log of the Pharmacy Review of Physician Orders for January 2011 and February 2011 was also provided. The following data were tabulated from the documents provided:
<table>
<tr><th></th><th>October</th><th>November</th><th>December</th><th>January</th><th>February</th></tr>
<tr><td>Total Interventions Documented</td><td>38</td><td>20</td><td>17</td><td>70</td><td>56</td></tr>
<tr><td colspan="6">Categories of Intervention (%)</td></tr>
<tr><td>Incomplete Orders</td><td>37</td><td>80</td><td>76</td><td>49</td><td>45</td></tr>
<tr><td>Drug Interactions</td><td>11</td><td>--</td><td>18</td><td>24</td><td>9</td></tr>
<tr><td>Non-Formulary Request/Not Available</td><td>26</td><td>10</td><td>0</td><td>10</td><td>25</td></tr>
<tr><td>Therapeutic Duplication</td><td>11</td><td>--</td><td>6</td><td>4</td><td>4</td></tr>
<tr><td>Allergies</td><td>5</td><td>--</td><td>--</td><td>--</td><td>4</td></tr>
<tr><td>Wrong Dose/Form</td><td>3</td><td>5</td><td>--</td><td>9</td><td>7</td></tr>
<tr><td>Wrong Drug</td><td>--</td><td>--</td><td>--</td><td>--</td><td>4</td></tr>
<tr><td>Illegible Order</td><td>--</td><td>5</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Multiple</td><td>3</td><td>--</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Other</td><td>5</td><td>--</td><td>--</td><td>4</td><td>2</td></tr>
</table>
</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		The Pharmacy Clinical Interventions document and Pharmacy Review of Physician Orders provided similar information with some particular differences. The clinical intervention document specified the medication order, type of intervention, resolution, and comments. The pharmacy review provided the medications involved, problems with order, MD response, and resolution. The clinical interventions document provided a more concise statement of the problem and resolutions. The average number of interventions reported as clinical interventions was 25. The average number reported in the pharmacy review was 63. The reported interventions were on a downward trend, but increased four-fold with the document change. The majority of interventions were due to incomplete orders. This included a lack of dose, route, indication, and stop dates. Numerous interventions occurred due to orders written for non-formulary medications or medications that were not available. It was noted that orders for drugs (Lithium CR) continued to be written after an availability issue was detected. Lack of availability was due to manufacturing problems. Interventions due to potential drug interactions were reported relatively frequently. Issues related to therapeutic duplication were noted in all months with the exception of November 2010. The acting pharmacy director reported that this information was provided to the medical director who shared it with the physicians during the monthly medical meetings. Documentation of those meetings was provided. A review of graphs for the months of December 2010 and January 2011 indicated no issues related to therapeutic duplication. The monitoring team, however, noted therapeutic duplication in December 2010 related to the drug lisinopril. The name of the individual was not provided. In January 2011, therapeutic duplication was noted for Individual #43, Individual #177, Individual #252, and Individual #218. In each instance, the physicians responded with appropriate individual corrective actions. Corrective actions based on aggregate data included: • Reminding physicians to review all orders for completeness • Completion of non-formulary request ASAP <u>Additional Discussion:</u> The reason for the change in reporting documents was not clear. Pharmacy policy cited the clinical interventions log as the document of record. The medical director should ensure that there were no process changes that resulted in significant changes in the number of interventions reported.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The data from the reports should be reviewed to ensure that appropriate issues are being captured. This is necessary so that physicians will be aware of issues, such as therapeutic duplication, allergies, and providing the appropriate form of medication for individuals with enteral tubes.</td><td></td></tr>
<tr><td>N2</td><td>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-therapeutic medication values.</td><td>The clinical pharmacists completed quarterly drug regimen reviews in a timely manner. The QDRRs included reviews of allergies, the appropriateness of medications, rationale for therapy, proper utilization, duplication of therapy, polypharmacy, drug – drug/food/disease interactions, and adverse reaction potential.

The clinical pharmacist submitted completed DRRs to the medical director's office for distribution to the medical staff. MSSLC policy required physicians to review the DRR, sign, and record agreement or disagreement with the recommendations of the pharmacist on the DRR form. An explanation was required when the physician disagreed with the recommendations. The physician was required to document this in the IPN as well. The physicians returned the documents to the pharmacy following completion. Timelines for physician completion and return were not specified in policy.

A sample of 30 DRRs was reviewed for timelines, pharmacy assessment, and physician response. The table below captures the key dates, drugs with monitoring parameters, pharmacy comments/recommendations, and physician responses. Listing of monitoring parameters indicated that the clinical pharmacist noted them on the actual DRR Report. Abnormal values are included in the table. The "discussion" represents comments from the monitoring team.

<table>
<tr><th>Individual</th><th>Key Dates
Completion
Pharmacy
Sign/PCP
Sig/Psychiatry Sig</th><th>Drugs, Monitoring, Comments/Recommendations</th></tr>
<tr><td>104</td><td>12/8/10
12/8/10
12/27/10
1/4/11</td><td>• Trazodone
• Quetiapine, risperidone - BMI, Lipids, FBS
• Visual exam for Seroquel 9/10
• Benztropine</td></tr>
<tr><td>238</td><td>12/27/10
12/27/10
12/30/10
12/29/10</td><td>• Methylphenidate – Ht and wt
• Quetiapine – BMI 43, 41, FBS, lipids LDL <132 – no clinical significance per PCP, eye exam 12/10</td></tr>
<tr><td>509</td><td>12/8/10
12/8/10
12/27
1/4/11</td><td>• Atenolol - BP, HR, CMP, EKG – sinus arrhythmia not clinically significant per PCP
• Sertraline</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status			Compliance
		374	12/6/10 12/6/10 12/27/10 1/4/11	• Quetiapine - BMI 22.9, lipids, visual exam 7/10 • Divalproex - VPA level, CBC – mild anemia	
		187	12/2/10 12/9/10 12/27/10 1/4/11	• Combivent inhaler, Montelukast • Desmopressin - CMP • Mirtazapine	
		56	12/14/10 12/14/10 12/27/10 1/4/11	• Trazodone, - EKG - WNL • Benztropine Lorazepam • Divalproex - VPA levels 112.2, CMP, CBC - Hb 12, no changes needed per IPN • Vitamin D- Vit D level • Ziprasidone, Risperdal – BMI 31.2, FBS, lipids, eye exam - WNL • Levothyroxine - TSH 2.18 Comments: Polyphamacy, but reviewed by polypharmacy committee PCP Comments in chart**:** Higher VPA levels need for treatment of mood disorder	
		6	12/13/10 12/13/10 12/27/10 1/4/11	• Propranolol – BP and HR monitoring • Lorazepam • Ziprasidone - BMI 25.7, FBS, Lipids Chol 171, TG 159, LDL 110 – no meds needed at this time, eye exam – WNL	
		539	12/17/10 12/17/10 12/30/10 12/29/10	• Desmopressin - CMP • Olanzapine- BMI 19, 23.7 23.9, FBS, lipids HDL 38 – nothing clinically significant, eye exam 1/26/10 • MVI Discussion: Would have been helpful to provide recommendation to complete eye exam	
		375	12/7/10 12/7/10 1/4/11 1/4/11	• Clonazepam • Risperidone - BMI 42, FBS, Lipids TG 159 HDL 29 – no meds needed per PCP, visual exam – WNL • Currently on risperidone 12mg, max recommended dose is 8mg • Paroxetine Benztropine, Citalopram, Pantoprazole • Docusate sodium, psyllium Recommendation: Currently on risperidone 12 mg, max recommended dose is 8 mg Psychiatrist response: Agree, see attachments	
		88	12/20/10 12/20/10 12/30/10 NA	• Miconazole powder – monitoring for improvement by nursing per chart	
		261	12/21/10 12/21/10 12/30/10 12/29/10	• Clonazepam • Olanazipine - BMI 24.4, 25.4, FBS, CMP, eye exam, no baseline lipids. • Paroxetine • Famotidine Recommendation: No baseline lipids. Please order Psychiatrist response: Will order	

#	Provision	Assessment of Status			Compliance
		37	12/20/10 12/20/10 12/30/10 12/29/10	• Atomoxetine – Height and Weight • Divalproex – VPA level, CMP, CBC • Olanazipine – BMI FBS, lipids, ocular 10/10	
		441	12/21/10 12/21/10 NA 12/29/10	• All medications were discontinued. Received multiple stat medications for aggression and SIB during past quarter Psychiatrist response: Contact [staff] to see if appointment needed	
		367	12/21/10 12/21/10 12/30/10 12/29/10	• Docusate sodium • Divalproex – VPA LEVEL • Chlorpromazine HbA1c, lipids, eye exam ordered by PCP • Desmopressin - CMP	
		557	10/11/10 10/12/10 NA 10/25/10	• Docusate sodium • Currently on 400 mg daily; recommended daily dose is 360 mg • Bisacodyl, polyethylene glycol • MVI, calcium, Vitamin D • Levothyroxine • Omeprazole, Prn rectal valium • Risperidone • Divalproex • Lamogitrine, carbamazepine - CBC monitoring with mild anemia – not clinically significant <u>Discussion</u>: DRR stated that PCP was contacted ON 10/12/10 and maintained regimen. This was not listed in the recommendation sections. No further recommendations related to bowel management.	
		303	10/11/10 10/11/10 No Date 10/25/10	• Basis soap • No indication but in med list. PCP contacted and dx of urticaria added • PEG, docusate sodium • Vitamin D, MVI, Calcium • Escitalopram Meloxicam • Phenytoin - No folic acid levels • Trazodone, Haloperidol • Omeprazole, Alprazolam, Benztropine <u>Discussion</u>: Neither finding is included under the recommendations section.	
		500	10/11/10 10/11/10 No date 10/25/10	• Calcium, MVI, ferrous sulfate • Vitamin D • Bisacodyl tab, docusate sodium • Carbamazepine, Pb • Alendronate • Doxycycline, Fexofenadine, Ranitidine,Trazodone Comments: Total Cholesterol 216 – addressed in IPN, low Hb/Hct addressed by MCP with ferrous sulfate <u>Discussion</u>: BMD and Vit D levels should be reported as well as AED drug levels. Drug levels and Vit D are noted on the worksheet.	

#	Provision	Assessment of Status			Compliance
		533	10/11/10 10/11/10 No date NA	• Psyllium, Esomepazole Doxycycline • MVI, ferrous sulfate, calcium/Vit D • HCTZ KCL • Levetiracetam • Lisinopril, Atenolol • Alendronate • Prn rectal valium Comments: Low Hb/Hct addressed by MCP with ferrous sulfate Discussion: No BP and HR monitoring; no CMP and Dexa/BMD on report; Vit D documented on worksheet	
		229	10/13/10 10/13/10 No date NA	• Calcium carbonate, MVI, Vit D, ferrous sulfate • Lactulose Doxycycline • Atorvastatin • Alendronate Comments: glucose sl elevated at 122, elevated retic, low transferrin, normal iron; MCP addressed with ferrous Discussion: No BMD and no lipids reported	
		525	10/14/10 10/14/10 None NA	• Divalproex • Levothyroxine • Atorvastatin Comment: Dx changed to seizure disorder Discussion: No TSH or lipids in report. Both on worksheet	
		172	10/18/10 10/18/10 No date 10/25/10	• Docusate, bisacodyl, doxycycline • MVI, Vitamin D, calcium • Carbamazepine, levetiracetam • Alendronate • Thioridazine Discussion: No drug levels, Vit D, CMP, CBC in report comments but documented on worksheet.	
		228	10/15/10 10/15/10 No date 10/25/10	• Calcium • Divalproex • Doxycycline Sertraline • Alendronate Comments: Na 130 – no action necessary per MCP Discussion: No Vit D or DEXA on report, but Vit D on worksheet	
		431	11/16/10 11/16/10 12/20/10 12/31/10	• Levothyroxine – TSH • Divalproex – level 78, CBC • Desmopressin - CMP • Esomeprazole Advair, alprazolam escitalopram • Quetiapine – Glucose, lipids, eye exam 9/28/10	
		259	11/19/10 12/20/10 12/20/10 NA	• EPI-pen is only med	
		464	11/19/10 11/19/10 No Date	• No meds at this time	

#	Provision	Assessment of Status			Compliance
			NA		
		181	11/17/10 12/20/10 12/31/10	• Docusate calcium Esomeprazole Escitalopram • Quetiapine - BMI monitoring, eye exam 5/10 • Amlodipine - BP/HR monitoring; no CMP in chart but ordered for 4/11 • Fluvastatin - lipids and LFTs not in chart, but scheduled for 4/11 • Glyburide - HbA1c 9.0, glucose 351 – addressed in IPN with dietary consult, clinic appt. • Bupropion Prn Clonazepam Recommendations: Currently on docusate 480 mg, max dose is 240mg daily. PCP response: Agree Discussion: No other record of monitoring parameters for DM such as microalbumin, etc.	
		131	10/22/10 10/11/10 11/13/10 12/11/11	• Vit D, MVI, Calcium, ferrous sulfate, PEG, • Atorvastatin - Started 4/22/10 and checked LFTs 5/24/10 • Divalproex - CBC monitored, hematology consult • Levothyroxine – • Alendronate - BMD 1/1010 • Risperidone • Clonazepam • Prn Rectal valium Discussion: TSH and Vit D included in worksheet but not in report.	
		231	10/25/10 10/25/10 11/13/10 NA	• PEG, Doxycycline • Calcium, Vit D, MVI - refused DEXA • Estradiol • Lasix - BP monitored • Fluconazole - Hepatic fx monitored	
		341	10/29/10 10/29/10 11/13/10 12/1/10	• PEG Calcium Doxycycline, omperazole • Carbamazepine – Drug level, CBC with stable anemia due to CKD • Risperidone - chol 221; reviewed by PCP 4/10; nothing clinical at this time • Clonazepam • Lisinopril – CMP (4/10) monitored, NA 133 Cl 94; nothing clinical at this time; renal fx normal (6/10) • Rectal valium Recommendations: PCP Response: Agree	
		390	10/29/10 10/29/10 11/13/10 12/1/10	• Vitamin D, VMI, calcium • Lorazepam omeprazole • Docusate, lactulose Doxycycline • Atenolol • Levothyroxine • Alendronate - BMD 7/2009 • Quetiapine • Atorvastatin - Lipids HDL 34, Alkphos 132 – reviewed by PCP 5/3/10 in IPN	

#	Provision	Assessment of Status	Compliance
		<table><tr><td></td><td></td><td>Recommendations: Psychiatry response: Att to medical clinic, high priority</td></tr></table> Overall, the DRRs were well done, documented significant findings, and provided evidence that the clinical pharmacist completed record audits. Laboratory values included the interpretation of "WNL", "high," or "low." References to the IPNs were frequent and included the date of the note and the physician's comments regarding the issue. When studies were indicated and were to be completed in the future, the date of the study was provided. It was clear that a great deal of effort was involved in gathering information for the reports. There were, however, some concerns noted with the documents included in the sample. The reviews were sometimes inconsistent in that reporting for a particular drug varied from individual to individual. The report for Individual #509 noted that heart rate and blood pressure were monitored because the individual received atenolol. The report for Individual #390 did not include those comments for the use of atenolol. None of the DRRs in the sample reviewed discussed the potential drug interaction, although the checkbox indicated potential interactions. In several instances, the reports did not include data that were found on the worksheets. Many of the worksheets indicated that the individual did not receive adequate calcium, yet providing calcium supplementation was never included as a recommendation. The use of benzodiazepines and anticholinergic burden were addressed in the worksheets, but this information was not included within the actual report. It appeared that the DRR Reports, as well as the worksheets, were included in the record. Worksheets, as can be expected, may contain notes, etc. Data from the worksheet should be included in the actual report, which would eliminate the need to include the worksheet in the record. When included in tabular format, the physicians may more easily note trends in values. This would be especially helpful in determining adverse reactions related to statins (LFTs), new generation psychotropic (lipids and HbA1c), and AEDs, such as carbamazepine (sodium). The normal range of values should also be included. The recommendation section should include any items where action may be necessary on the part of the physician. If no folic acid level was found and the study is indicated, it should become a formal recommendation. This will ensure that recommendations are seen by the physician and will make tracking an easier task.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical	The drug regimen reviews addressed the monitoring of benzodiazepines, anticholinergic and polypharmacy. The metabolic risks associated with the use of the new generation antipsychotics (NGA) were also addressed in the drug regimen reviews. The MOSES instrument often noted changes in weight that could be attributed to the use of NGAs.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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 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.	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. Polypharmacy discussion was also documented in the quarterly Pharmacy and Therapeutics committee meeting minutes. Polypharmacy is discussed further in Section J.	
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 MSSLC Quarterly Drug Regimen Review Policy required that in those cases where recommendations were made, the physician will state whether he/she concurs or not." This will be documented in the integrated progress notes, including the reason for disagreeing. Two mechanisms tracked physician responses to recommendations made by the pharmacist. Prospectively, the Clinical Interventions Log contained information on physician responses prior to dispensing drugs. The medical director reviewed these data with physicians at the monthly meeting. Retrospectively, the Review of Quarterly Drug Regimen Reviews specifically addressed physician responses to the recommendations included in the drug regimen reviews. Data on tracking for October 2010 to December 2010 was reviewed by the monitoring team. Three hundred twenty DRRs were reviewed by medical services. Fifty-five recommendations were generated from DRRs. Physicians agreed with the recommendations in 38 of 55 (70%) instances. Disagreements were most often related to issues of psychotropic dosages above the state formulary recommended doses, requests for baseline data, and discrepancies in MOSES/DISCUS forms being completed. This audit did not provide information on the documentation of agreement/disagreement in the actual IPN. The current policy requires documentation on the report form as well as the IPN. Documentation of discussion of this data was not provided. It would seem appropriate to add this information to the discussion of the clinical intervention data.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
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 sample of MOSES and DISCUS forms listed above was reviewed for timelines for completion and review, thoroughness and physician response. The results are presented below.	Noncompliance

Individual #	MOSES Reviewer Date Physician Date	MOSES Comments	DISCUS	TD
365	10/20/10 10/21/10	Total score 3 MD Conclusion: NAN	10/20/10	No
310	10/13/10 10/14/10	Total score 3 - 7.2# wt gain for qtr MD Conclusion: NAN		No
562	10/4/10 10/7/10	Total score 17 MD Conclusion: NAN	10/4/10 10/7/10	No
335	10/20/10 10/21/10	Total score 16 MD Conclusion: NAN	10/20/10 10/21/10	No
Wilson	10/13/10 10/221/10	Score 3 - 13# wt loss QTR MD Conclusion: NAN	10/12/10 10/21/10	No
Back	11/1/10 No MD Sig	Score 1 MD Conclusion: NAN	11/1/10 11/11/10	No
159	8/11/10 8/11/10	Score 1 MD Conclusion: Unstable, needs hospitalization	8/11/10 8/11/10	No
Brown	8/20/10 8/15/11	No score 0 MD Conclusion: Improving and relatively stable	8/25/10 8/25/10	No
225	6/17/10 No MD Sig	Score 1 - wt gain is desirable MD Conclusion: --	6/17/10 No MD Sig	No
74	10/12/10 10/14/10	No score 0 MD Conclusion: --	10/12/10 10/14/10	No
462	12/16/10 12/16/10	No score 3 MD; Drug changes	12/16/10 12/16/10	No
217	9/23/20 No MD Sig	No score 4 - 38# wt gain in 2 months MD Conclusion: Other	10/21/10 10/21/10	No
217	10/21/10 10/21/10	Score 1 MD Conclusion: Begin Topamax for appetite suppression		No
503	12/1/10 1/12/11	Total score 3 MD Conclusion: NAN	5/12/10 5/17/10	No
526	8/19/10 8/20/10	Total sore 7 MD Conclusion: --	8/19/10 8/20/10	No
454	8/19/10 No MD Sig	Total score 2 MD Conclusion: --	8/19/10 8/20/10	No
306	8/19/10 No MD Sig	Total score 8 MD Conclusion: --	8/19/10	No
143	10/4/10 10/4/10	Total score 15 - Tremors MD Conclusion: --	10/4/10 10/4/10	No
293	10/7/10 10/11/11	Total score 20 MD Conclusion: --		No

#	Provision	Assessment of Status	Compliance

339	10/4/10 10/5/10	Total score 0 MD Conclusion: --	12/27/10 1/11/11	No
386	10/5/10 10/5/10	Total score 0 MD Conclusion: --	10/5/10 10/5/10	No
21	10/4/10 10/5/10	Total score 0 MD Conclusion: --	10/4/10 10/5/10	No
353	10/12/10	Total score 0 MD Conclusion: --	10/12/10	No
463	10/12/10 10/12/10	Total score 1 MD Conclusion: --	10/12/10 10/12/10	No
475	12/21/10 12/21/10	Total score 0 MD Conclusion: NAN	12/21/10 12/21/10	No

The MOSES and DISCUS forms were completed based on agency policy. There were very few instances in which there was a delayed physician review. There were a few MOSES documents that appeared to not have been reviewed by a physician. In the sample, there were documents that indicated weight loss or weight gain, but the physician did not comment on the relevance of medications. In addition to this, there were several MOSES documents reviewed and signed by the physician, but the physician failed to check a conclusion.

The use of these side effect treating tools appeared to be limited. None of the neurology clinic notes included a review of these tools although the intent is to provide practitioners with valuable information regarding medication side effects. The PCPs, as the practitioner with ultimate responsibility for management of health concerns, should also review and utilize this information and it would be appropriate to document such information in quarterly summaries.

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.

Compliance: Noncompliance

According to the facility's POI, the revised Adverse Drug Reaction Reporting policy had been implemented following the training of all staff. The acting pharmacy director reported that adverse drug reactions were being reported utilizing the new reporting form. This procedure was implemented 2/17/11 resulting in generation of minimal data prior to the onsite review. The facility did not provide ADR reports, but provided a spreadsheet "MSSLC Adverse Drug Reaction Log" that contained information extracted from the integrated records and other documents on the previous adverse drug reactions of individuals as well as recent ADRs. Eight incidents were reported from October 2010 through January 2011:

Individual #	Date of Incident	Drug Suspected	Type of Reaction(s)	Disposition
477	10/18/10	Thorazine	Increased alkaline phosphatase	N/A
57	11/2/10	Clonazapine	Parkinson	N/A

#	Provision	Assessment of Status	Compliance

300	12/1/1o	Divalproex	Anemia	N/A
549	12/6/10	Tegretol, Depakote	Pancytopenia	N/A
438	12/16/11	Gabapentin, PCN, sulfa drugs	Thrombocytopenia	N/A
261	1/7/11	Olanzapine	Elevated triglycerides	Medication stopped and reaction abated
543	1/12/11	Divalproex, quetiapine, sertraline, fenofibrate, simvastatin,	Pancreatitis	Divalproex and simvastatin discontinued. Individual recovering
261	1/18/11	Depakote	Sub conjunctival hemorrhage	Medication stopped and reaction abated

The possible ADRs that resulted in pancyctopenia and pancreatitis likely warranted further investigation. An ADR policy that clearly defined clinical outcomes, severity scales, and thresholds for intense case analysis would trigger this process to begin after discovery of a serious reaction.

The current MSSLC ADR system lacked both the use of a probability scale and a severity scale. The probability scale provides an objective rating system while the severity scale addresses outcomes through a ranking system. These deficits were discussed with the acting pharmacy director and medical director during the onsite review.

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 two Drug Use Evaluations since the last onsite review. The findings of the DUEs had the potential to have significant population impact because the drugs selected belonged to the high use, high-risk category. Notwithstanding good drug study selection, there were significant problems with the DUE process because there was no operational procedure to define the process and ensure that all components of the Health Care Guidelines were met. Data collection forms for the Quetiapine DUE as well as the Dilantin Retrospective DUE were submitted in response to a request for all DUE reports and background information. Minutes of the Pharmacy and Therapeutics Committee meetings were also provided. <u>DUE #1 – Quetiapine Drug Utilization Evaluation</u> There was no summary report for this DUE. Data collection forms were reviewed. The acting pharmacy director reported that all individuals receiving the drug were reviewed. The data collection was completed by the treating psychiatrists and reviewed by the clinical pharmacist. The P&T minutes dated 12/20/10 summarized the DUE findings. Fifty-three individuals	Noncompliance

#	Provision	Assessment of Status	Compliance
		were evaluated by the pharmacy for Seroquel use. Findings showed that all individuals reviewed had proper indications with proper documentation. Lab monitoring was appropriate and all doses were within the recommend range for the drug. DUE #2 - Retrospective Drug Utilization Evaluation Phenytoin was chosen for the DUE due to high-risk potential associated with this drug. Objective: The objective was to evaluate the justification for phenytoin, assess for adverse reactions, asses compliance with monitoring and bring forth suggestions for future dilantin DUEs. Methodology: The DUE was a retrospective review of all individuals at MSSLC who were on phenytoin as of January 2011 (n=25). A data collection form was developed to assess for the first three objectives listed above. Physicians completed the data collection forms and submitted them to the clinical pharmacist. Results: Indications for use included generalized tonic clonic seizures (8 individuals), complex partial seizures (13), and other (6). The DUE reported that 5 of 25 individuals had drug interactions with phenytoin. Adverse effects were present in 14 of 25 individuals. There was 100% compliance with monitoring parameters. Two individuals exhibited supra-therapeutic phenytoin levels, but only one exhibited clinical toxicity. Recommendations included continued monitoring and suggestions to prevent gingival hyperplasia. Additional Discussion The phenytoin DUE reported that one individual had clinical toxicity associated with dilantin use. The study did not specify the timeframes for data collection or when the toxicity occurred. No adverse drug reactions were reported during the last six months related to dilantin toxicity. A DUE that detects current or recent toxicity should result in generation of an ADR. An ADR that results in clinical toxicity warrants further review and might potentially require an intense case analysis. None of the reported adverse effects resulted in generation of ADR reports. Moreover, there were several recommendations related to oral health and gingival hyperplasia. Attention to oral health is a valid issue for those receiving phenytoin. The DUE did not indicate how many individuals had a diagnosis of gingival hyperplasia related to phenytoin use. During the March 2011 P&T Committee meeting, the acting pharmacy director clarified the drug interactions as potential interactions.	

#	Provision	Assessment of Status	Compliance
		A DUE calendar was completed and included plans to assess the use of lithium and depakote. Both of these represent good selections as part of the high use, high-risk categories of drugs. The calendar included interventions and follow-up for the two future DUEs. The data obtained from the DUE should drive the interventions and follow-up. The calendar could include the objectives of the DUE or the rationale for selecting the drug for study. The formats of the two DUEs differed. There was no report generated by the quetiapine DUE. The phenytoin DUE was described as a retrospective DUE. It was, in fact, a concurrent DUE since it was performed during treatment and involved the ongoing monitoring of drug therapy on outcomes. It allowed for intervention and alteration of therapy. The prescribing physician completed the data collection tools for both DUEs. Concurrent and retrospective DUEs assess many factors including practitioner prescribing patterns and compliance with monitoring. An objective reviewer should complete data collection. A summary report should be created for each DUE. Formats and content may vary but there are some key elements that should be included: 1. Title of DUE 2. Staff completing DUE 3. Dates of review 4. Date report presented to P&T 5. Objectives of DUE 6. Background information – including the rationale and baseline performance 7. Criteria for evaluation and process for development 8. Methodology – describe the data, data collection process and timeframes as well as the populations being studied 9. Results – include timeframes, number of charts reviewed 10. Conclusions – include answers to the objectives and other information discovered 11. Recommendations – include specific action steps to impact the results/conclusions, timelines for implementation and a plan for follow-up 12. Any references utilized The facility should draft an operation procedure for the DUE process. It should be consistent with the Health Care Guidelines, but provide specific and clear directions for the process.	

#	Provision	Assessment of Status	Compliance
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 potential medication variances.	The facility maintained a process for collecting and analyzing medication variance data. The Medication Error Review Committee met monthly to review data and determine corrective actions. Medication variance data was also summarized at the quarterly Pharmacy and Therapeutics Committee meeting. A summary of medication variance data is presented below. These data were discussed during a meeting with the clinical pharmacist, medical director, and acting chief nurse executive. Subsequent discussion occurred with the QA nurse.	Noncompliance

MEDICATION ERRORS
JULY 2010 - JANUARY 2011

	July	Aug	Sept	Oct	Nov	Dec
Point of Error						
Prescribing	0	0	0	3	0	0
Administration	14	49	57	90	75	109
Documentation	8	11	43	76	30	21
Monitoring	0	1	0	0	1	0
Dispensing	0	1	2	5	2	2
Total	21	59	90	133	102	121
Type of Error						
Wrong Person	0	6	3	0	1	1
Wrong Drug	0	0	0	4	1	1
Wrong Dose	13	25		93	47	95
Improper Dose	0	6	14	14	28	7
Serious Error	1	0	0	0	0	0
Severity Index						
A	1	2	14	11	7	7
B	1	2	18	17	15	3
C	14	49	53	97	76	108
D	4	6	5	8	4	1
E	1	0	0	0	0	0
Pharmacy Medication Returns						
Number of Doses Returned	--	--	--	688 doses	497 doses	931 doses

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Reconciliation Rate (%)	--	--	--	46	52	54	

Types of Errors

July 2010

- One serious error was reported. "The individual was prescribed phenobarbital 100 mg given every HS for seizure disorder. The dose was omitted on July 29th. On July 30, the individual suffered one minute of seizure like activity, which may or may not have been caused by the missed dose. The individual recovered without any further adverse effects."
- Two errors were attributed to illegible handwriting of a contract physician but no prescribing errors were noted.

August 2010

- There were 6 wrong patient errors. In 2 cases, the medications were in the wrong drawer.
- An individual grabbed another individual's medications from the counter and took them despite being told not to do so.
- An order for erythromycin ointment was written on the wrong individual's MAR.
- The LVN accidentally gave an individual another individual's meds, realized the mistake, and immediately self-reported.
- An individual was given another individual's blood pressure medication.

December 2010

- Wrong patient error with incorrect Xanax dose
- Improper dose quantity

The contributing factors were discussed at each MERC meeting and similar issues were noted monthly including the impact of agency nurses on medication errors, inexperienced staff, floating staff, and inadequate staffing. Distractions were also cited as contributing factor yet no specifics were provided.

The minutes of each MERC meeting discussed findings from the monthly Medication Pass Observations. Recommendations for corrective actions were also documented in the minutes. Several of these issues, such as incomplete physician orders have been detailed in other sections of this report section N. Concerns generated included:

- Abbreviations appearing on MAR generated from pharmacy department. Pharmacy Department does not use approved abbreviations per policy and procedure.
    - This concern was cited from August 2010 through November 2010. A

#	Provision	Assessment of Status	Compliance
		new abbreviation list was targeted to be implemented by the end of January 2011. • Nurse managers need to provide additional training related to complete physician orders, completion of MARS and provision of training to DCP on health care issues. • PCP orders clearly fail to state the exact parameters of monitoring and what changes should be brought to the attention of the PCP. • Failure to consistently have two-person count of controlled substances at 2:00 pm daily. • Failure of nurse managers to address medication concerns addressed on the observation passes and monitoring tools. • Failure of nursing staff to receive quarterly med administration pass observations. • MARs fail to identify start/stop dates. • Failure to identify individual prior to administration. • Failure to initial MAR. • Failure to identify crushed meds. • Physician orders and MAR not in agreement. • Master legend list fails to match initial on MAR. Notably absent from the minutes of the two January 2011 meetings was a possible variance related to dilantin toxicity. The monitoring team requested information related to an individual with dilantin toxicity. The QA nurse reported that the individual had clinical dilantin toxicity and the physician ordered the medication to be held. When the medications were eventually returned to the pharmacy, the amount of medication returned appeared too small, given the order to hold the medication. The CNE and medical director were both aware of this incident, but there was no discussion in the two MERC meetings that followed the incident. This incident was worthy of greater scrutiny to determine the potential of being an error. The monitoring team did not receive a definitive answer related to this event. Given the number of medications that were returned to the pharmacy with no explanation, and understanding that reconciled returns may represent additional errors, the facility must devote time and resources to this issue. There must be accurate data on the pharmacy returns.	

Recommendations:

1. The facility should utilize one document to record the interactions between the physicians and pharmacists related to medication orders.

2. The medical director should ensure that the clinical intervention data is accurately capturing problems associated with medication orders.

3. The medical director should continue work with the medical staff in achieving a high rate of complete orders.

4. When issues such as availability off drugs arise, there should be a system to notify all physicians that the drug is not available, and provide an expected date of return to stock. This will prevent the same non-available order from being written by other physicians on multiple days.

5. The allergy database should be available to everyone involved in clinical care. It should be accurate and updated when changes occur. The integrated records should have the appropriate allergy warnings.

6. The drug regimen reviews should comment on every medication with an established monitoring parameter. This should be done with each review. A table could be included in the report form that contained the relevant labs such as lipids, glucose and liver enzymes. When presented serially in table format, the physicians will be able to easily detect trends and adverse reactions.

7. When the drug regimen review indicates potential drug interactions, those interactions should be briefly discussed on the report form. The anticholinergic burden should also be included in the actual report.

8. The medical director should track compliance with responding to the recommendations of pharmacists and documentation in the IPN and DRR report form. This data should be discussed with the physicians in addition to the clinical intervention data at the monthly Medical Review meeting.

9. The ADR policy must be revised to include the use of an objective rating instrument, a severity scale and a threshold for completion of an intense case analysis or investigation. Suspected adverse drug reactions that result in hospitalization should be brought to the attention of the Quality Enhancement and Risk Management Departments.

10. The medical director should ensure that the medical staff are appropriately reviewing the MOSES and DISCUS forms and commenting as required.

11. The facility must determine why such large numbers of medications are returning to the pharmacy. The facility must also ensure that serious medication errors receive appropriate attention. Consideration should be given to having the QA Department become more involved in this process.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o PNM Team members list o CVs (Brenda Howell OTR, Sandra Opersteny, PT, Jennifer Capers LD, Dawn Price, RN) o Continuing Education documentation for PNMT o MSSLC POI for Section O o MSSLC Organizational Charts o Staffing data (2/15/11) o Current Census Counts by Home (3/13/11) o List of new admissions o Risk Guidelines o PNMT meeting minutes and agendas (12/27/10, 1/27/10, 3/17/11) o Nutritional Management Committee meeting minutes (8/17/10, 9/14/10, 10/14/10, 11/9/10, 12/9/10) o OT/PT/SLP Evaluation Update template (draft) o Aspiration Pneumonia/Enteral Nutrition Evaluation template o PNMT Evaluation template o At Risk Individuals Policy #006.1 o Completed Aspiration Trigger sheets submitted o HOB elevation evaluation datasheets o PNMPs submitted o Dining Plans submitted o Positioning plans submitted o Orthotics plans submitted o PNMP list 2/11/11 o PNM curriculum for NEO o Settlement Agreement Cross Referenced with ICFMR Standards Section P template o Pressure Wounds list (2/15/11) o List of individuals with skin breakdown, decubitus ulcer o List of individuals with contractures o List of individuals with BMI greater than 30 and less than 20 o List of individuals with poor oral dental status o List of individuals with aspiration or pneumonia incident in the past 12 months o List of individuals with choking incident o List of individuals with dysphagia o Modified Barium Swallow Studies of 2010

	o Individuals with fecal impaction or constipation in the last 12 months o List of individuals on modified diets/thickened liquids o Individuals with diet downgrade in the past 12 months o List of individuals with unplanned weight loss of 10% or greater in six months o List of individuals with chronic respiratory infections o List of individuals with weight loss or gain o List of individuals with impaction /bowel obstruction/constipation o List of individuals with dehydration, chronic dehydration o List of individuals with metabolic syndrome o List of individuals with seizures o List of individuals who require mealtime assistance o List of individuals with GERD o HST risk assessment ratings (2/16/11) o List of individuals with chronic and acute pain o List of falls in the last 12 months o List of individuals with osteoporosis/osteopenia o List of fractures o List of fractures choking and falls with injury in the last six months o Documentation regarding choking and fracture events from nursing o Incident reports and documentation regarding choking events for: • Individual #505, Individual #66, Individual #567, Individual #215, Individual #117, Individual #4, and Individual #333 o List of hospitalizations/ER visits o List of individuals who were non-ambulatory and assisted ambulation o List of individuals with wheelchairs as primary mobility o List of individuals with transport wheelchairs o List of individuals with assistive ambulation devices o List of individuals with orthotics and/or braces o List of individuals with decubitus/pressure ulcers during the past year o List of individuals who experienced a falling incident during the last three months o List of individuals with and without PNM needs o Completed PNMP Observation Sheets submitted o Completed Comprehensive Monitoring Forms submitted o PNMP list of individuals who were monitored in the last quarter o Enteral Feedings list o List of individuals who died in the last year and cause of death o PNM-related training rosters submitted o Therapeutic and Pleasure Eating Protocol o Full medical record for Individual #72 o PSPs, all PSPAs, PBSPs, Physician Annual Medical Reviews, Active Problem List, hospital records, Health risk Assessment Rating Tool, Integrated Progress Notes for 12 months, nursing assessments and quarterlies, documents in Habilitation tab of record, swallow studies, x-ray

	reports, nutrition assessments, notes and updates, PNMPs (12 months), Dining Plans (12 months), positioning instructions and pictures, orthotics plans and pictures, other Habilitation Therapy plans, communication plans (none submitted), communication dictionaries, monitoring checklists (three months), weight records/BMI (12 months), communication-related assessments for: • Individual #435, Individual #40, Individual #38, Individual #542, Individual #79, Individual #293, Individual #477, Individual #143, Individual #285, Individual #369, Individual #188, Individual #321, Individual #432, Individual #494, Individual #469, Individual #567, Individual #328, Individual #518, Individual #151, Individual #503, Individual #257, Individual #16 and Individual #304. There was no evidence of communication assessments for Individual #542, Individual #257 or Individual #304 in the records submitted. Interviews and Meetings Held: o Brenda Howell, OTR Habilitation Therapies Director o PNMT members o PNMP Coordinators o Habilitation Therapies staff o Various supervisors and direct support staff Observations Conducted: o Living areas o Dining rooms o Day Programs o PNM Clinic o Wheelchair Clinic
	Facility Self-Assessment: MSSLC's self-assessment rated noncompliance for all items of this provision. Systems were in the process of development, particularly the new PNMT process. This self-assessment was consistent with the monitoring team's assessment of noncompliance. The POI may be more useful if there were also action steps listed designed to achieve compliance with the status of completion and evidence to illustrate this included in the plan. The current format merely listed activities, but did not present an understanding of the steps and strategies required to meet the provisions with timelines of completion. This kind of format would offer more of a roadmap for all staff and a means to direct their focus, effort, and energy.
	Summary of Monitor's Assessment: The PNMT process was not initiated, other than to begin to identify team members with four organizational meetings. There had been no individual-specific reviews completed and the team membership was still in question with regard to the nurse. One of the new contracted OTs was designated to participate, but had not yet completed NEO. The team was planning to transition to a full-time dedicated team because

	referrals increased. There will be a significant period of growth as they attempt to clearly establish roles and responsibilities. The target start date was designated as 4/1/11. The risk assessment process and aspiration initiatives were also new processes and will require significant and thorough review in six months. This team will need to work diligently as they serve as both the PST members and adjunct PNMT members so that they can carefully examine each case in a new manner so as to design and implement appropriate and effective intervention plans. There will be a balance of new staff (SLP and OT) as well as the relatively new director, who serves as chairperson, with existing staff and this should assist the team from this perspective. There continued to be implementation errors during meals, related to position and alignment, as well as assistance techniques, adaptive equipment, and diet texture and liquid consistency.

#	Provision	Assessment of Status	Compliance
O1	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	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** MSSLC had not formally initiated the new process for the Physical Nutritional Management Team (PNMT). The intended function of the team was to address individuals whose identified health status placed them at a high risk of potential or actual injury and/or illness. The initial step in this process was to identify PNMT members. The core members of the newly established Physical Nutritional Management Team (PNMT) included the following per the documentation submitted: • Brenda Howell, OTR Chairperson • Sandra Opersteny, PT • Doris Ricketts, OTR • Jean Reboli, MS, CCC-SLP • Jennifer Capers, LD • Dawn Price, RN At the time of the onsite review it was reported that there were to be a number of changes in the membership on the team: Ms. Howell would continue as Chairperson, Ms. Opersteny would continue as PT, and Jennifer Capers would continue as the dietitian. However, it was announced that Ms. Reboli's contract would be PRN only (due to finalizing the Guardian staffing contract) and another SLP provided via the state contract with Guardian would be assigned to the team. In addition, one of the OTRs through the Guardian contract would be assigned as a core team member as of 3/16/11. It was also undecided at that time if Ms. Price would continue as the RN on the team. Each of the therapy clinicians were responsible for a large caseload requiring them to complete assessments, attend PSP meetings, develop intervention plans, and provide monitoring	Noncompliance

#	Provision	Assessment of Status	Compliance
	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, 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.	and review. There were only two dietitians for the entire facility, so the PNMT dietitian also served in dual roles as a member of the team. The RN was also the Wound Care nurse. Though none of these clinicians were designated as solely assigned to the PNMT at the time of this review, the plan was to ensure that there was a dedicated team in the near future. A target date of 4/1/11 had been set to begin assessments by the PNMT. Permanent core team members planned to transition to full time as the PNMT caseload developed. There were approximately 216 (55% of the current census of 393) individuals identified with PNM needs per the list submitted. It was of great concern to the monitoring team that the facility was significantly delayed in implementation of this policy that had been in place statewide since October 2010. They had continued to function in the old NMT model through 12/7/10. Organizational meetings for the new PNMT were conducted on 12/27/10 and 1/27/11. These meetings included discussion about the roles and responsibilities of team members, the need to establish a dedicated team, and the new risk assessment process. A PNMT meeting was also held on 3/17/11 during the onsite review and was observed by the monitoring team. This meeting consisted of further organizational topics of discussion including head of bed assessments, vital stimulation presentation to the physicians, gastric emptying studies, designated positions, risk levels, and the target group for PNMT review. Supports, review, and follow-up for individuals previously served by the NMT would transition to the PSPs. Referrals to the PNMT would be made by the PSTs if they were not successfully meeting the PNM needs of those individuals identified at highest risk via the risk assessment process. Evidence of current licenses was submitted for Brenda Howell, OTR, Sandra Opersteny, PT, Jennifer Capers, LD, and Dawn Price, RN. Evidence was also submitted for Doris Ricketts, OTR, and Jean Reboli, MS, CCC-SLP, but, as stated above, it had been decided that these clinicians would not be core team members. Experience documented per the CVs submitted included: • Brenda Howell, OTR: Received a BS in Occupational Therapy in 1977. Worked as a staff therapist and in leadership roles at hospitals and rehabilitation centers. Served as a staff OT at MSSLC for two years in the 1970s and at Lufkin SSLC for four years in the 1980s. Served as OT Director at an ICFMR in another state for seven years. • Sandra Opersteny, PT: Received a BS in PT in1991 and a Masters of Education in Counseling in 1995. She is certified in Wound Care since 2008 and had worked at MSSLC since 1996 and at Lubbock SSLC for five years in the 1990s. • Jennifer Capers, LD: Received a BS in 1993 and has worked as a dietitian at MSSLC since that time. • Dawn Price: Stated that she had been a nurse for 26 years in a wide variety of	

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		settings. Actual dates and employment history were not documented. No other CVs for new members were submitted. Per the documentation submitted, participation in PNM- related continuing education for PNMT members since the previous review included: • Jennifer Capers, LD o Understanding Personality Disorders on 10/2/10 (6 CPEUs) o Overcoming the Challenge of Applying the Nutrition Care Process/Standardized Language to the Long Term Care Setting on 4/21/10 (2 CPEUs) o Other MSSLC inservice training including PSP training on 11/29/10. There was no evidence of continuing education in the last 12 months identified for any other PNMT members. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** The previous NMC meetings had been held monthly since the previous review on 8/17/10, 9/14/10, 10/14/10, 11/9/10, and 12/9/10. No further meeting minutes were submitted, though as stated above, some members of the newly formed PNMT met on 12/27/10 and 1/27/11. There was no list of attendees, however, included in the minutes. A subsequent meeting was held on 3/17/11 with the monitoring team in attendance. In attendance on that date were Jennifer Capers, Dawn Price, Sandra Opersteny, and Brenda Howell. Analysis of the previous NMC was not indicated because that system was no longer in effect. Though the NMC was no longer a functioning committee, the interim PNMT had continued to meet, though no specific individuals had not been assessed or reviewed as of the time of this onsite review. The team's ability to appropriately address change in status, assessments, clinical data, and monitoring results in a timely and comprehensive manner will need to be further evaluated during future onsite reviews.	
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	**Standard: A process is in place that identifies individuals with PNM concerns.** Per a list submitted for this onsite review, there were 216 individuals identified with PNM needs at MSSLC. Each of these were provided a PNMP. A new policy and process used to establish health risk levels had recently been implemented statewide. The goal was to have discussions of risk occur during each individual's PST meetings. At the time of this	Noncompliance

#	Provision	Assessment of Status	Compliance
	positioning assistance associated with swallowing activities, who has 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.	review, the teams were also attempting to integrate the new PSP process. The PSTs will require significant clinical instruction and support regarding risk assessment and real time modeling by state leaders (as was the plan) to effectively implement these new policies and procedures. Further evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The new statewide system to identify and manage individuals at risk was outlined in policy #006.1, At Risk Individuals, with an implementation date of 1/1/11. This policy was intended to identify individuals who were at risk for illness or injury as well as to identify actions and supports to mitigate the risks. The PST was to initiate assessment upon change in status for any individual to examine the existing support plans to ensure the appropriate measures were in place. The PNMT was defined as follows per this policy: "A team of specialists with knowledge and expertise in the development of Physical Nutritional Management Plans who meet to provide comprehensive assessment and determine appropriate intervention for persons whose identified health status places them at highest risk for potential or actual injury and/or illness. Members of the PNMT include the following disciplines: registered nurse, physical therapist, occupational therapist, dietician, speech pathologist and others as needed. All core team members should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. As requested the team shall include primary care providers, nursing case managers, therapists, psychologists, QMRPs, home supervisors, facility support services staff and others as needed." The PST was to refer individuals at high risk to the PNMT who were not stable and for whom the PST required assistance in developing a plan. The PNMT was to begin assessment within five working days of referral to determine possible causes for the change in status, to analyze assessment findings, integrate recommendations and to propose an action plan with measurable goals and outcomes. The complexity of PNM-related risk indicators require comprehensive and collaborative team assessment, intervention plan development, implementation, and monitoring. The process for risk assessment and the role of the PNMT had been recently implemented and further review will be necessary as these two systems evolve during the upcoming months. The current system of risk identification continued to be inconsistent and the monitoring team hopes that these issues will be resolved as the new systems are implemented.	
O3	Commencing within six months of	**Standard: All persons identified as being at risk and requiring PNM supports are**	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	**provided with a comprehensive Physical and Nutritional Management Plan (PNMP).** There were approximately 216 individuals identified with PNM needs and all (100%) had PNMPs. The PNMPs were generally of a consistent format and contained information related to the focus, hearing, vision, assistive equipment, mobility, transfers, movement instructions, positioning, mealtime instructions, communication, behavior concerns, medication administration, oral hygiene, bathing, and skin care. Most of the plans were dated, usually a staffing date, and included the date that the plan was reviewed or modified (update). An asterisk was intended to alert staff to changes in the plan from the previous version. Most of the plans reviewed were current within the last 12 months, though these plans were not dated: Individual #276, Individual #462, and Individual #340. Eight others were dated as implemented in 2009 or early 2010 (February or March) and past due for review. Each of these had an update in January 2011 or February 2011 for a "book change," but there was no evidence that they had been reviewed and/or updated by a therapist since the implementation date (Individual #540, Individual #528, Individual #278, Individual #203, Individual #330, Individual #226, Individual #49 and Individual #165). The monitoring team considered some or all of the following criteria in choosing 24 individuals for a record sample: • Emergency Room visits • Hospitalizations • NMT Committee meeting documentation • PNMT documentation • Individuals with active pressure ulcer within the last six 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	

#	Provision	Assessment of Status	Compliance
		administration, tooth brushing, personal care and functional communication The individuals selected included: Individual #293, Individual #72, Individual #477, Individual #38, Individual #79, Individual #304, Individual #369, Individual #151, Individual #328, Individual #567, Individual #16, Individual #542, Individual #188, Individual #432, Individual #285, Individual #567, Individual #143, Individual #518, Individual #494, Individual #321, Individual #40, Individual #503, Individual #435, Individual #257 and Individual #469. It appeared that the PNMPs were generally of a standardized format, though content and detail were inconsistent from plan to plan, not only related to individual differences. The PNMPs submitted for each of the 24 individuals for whom individual records were submitted were reviewed with findings as follows: • PNMPs were submitted for 24 of 24 individuals included in the sample. The sample size for PNMPs was considered to be 24 for the purposes of this review. • PNMPs for 24 of 24 individuals in the sample (100%) were current within the last 12 months. • In 24 of 24 of PNMPs reviewed (100%), mobility was addressed. • In 22 of 22 PNMPs reviewed (100%) for individuals who used a wheelchair as their primary mobility, general wheelchair positioning instructions for the wheelchair were provided, though most of these were very limited. • In 22 of 22 PNMPs reviewed (100%), the type of transfer was included or there was a statement indicating that the individual was able to transfer without assistance. In some cases, transfers were included in the same section as mobility and, for others, this information was included in a separate section and was easier to locate. • In 21 of 24 PNMPs reviewed (88%), the PNMP listed bathing instructions beyond the number of staff required. Three did not have specific bathing strategies, though these individuals appeared to require significant physical assistance for mobility and transfers (Individual #72, Individual #328, and Individual #477). In 18 of 18 PNMPs reviewed (45%), for individuals who were not described as independent with mobility or repositioning, handling precautions or instructions were included. Instructions for Individual #257 were unclear because the plans stated that she positioned and repositioned independently, but required the assistance of two staff for wheelchair positioning/repositioning. • In 22 of 24 PNMPs reviewed (92%), instructions related to mealtime were included, though the detail of those instructions varied greatly. • Thirteen of 24 individuals (54%) received enteral nutrition, though one of these also appeared to receive oral intake. Positioning for 11 of these individuals was included under the mealtime instructions section, though instructions were	

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		generally limited to the degree of elevation. In some cases, the plan only indicated that the individual should receive nothing by mouth. The plans for two individuals who received oral intake merely referred staff to the dining plan for meal and snack instructions (Individual #469 and Individual #328). The PNMPs varied with regard to specificity of instructions particularly related to bite size, pace, or other staff assistance techniques. • In 15 of 24 PNMPs reviewed (63%), dining position for meals or enteral nutrition was provided. Most merely indicated that the individual was to be upright during and after meals. • In 22 of 24 PNMPs reviewed (92%), diet orders for food texture were included for those who ate orally with statements related to enteral nutrition and instructions for nothing by mouth for those with non-oral intake. • In 10 of 12 PNMPs for individuals who received liquids orally (83%), the liquid consistency was included. • In 5 of the 12 PNMPs for individuals who ate orally (33%), dining equipment was specified in the assistive equipment section, but not in the mealtime or medication administration section, even when the individual used regular dinner ware and utensils. In one case, there was no adaptive mealtime equipment listed under assistive equipment or under the mealtime instructions, yet was included in the medication administration section of the plan (Individual #567). In the case of Individual #469, a high-sided dish and nosey cut out glass were listed under assistive equipment, but staff were merely referred to his dining plan for actual instructions. Individual #304 also had a nosey cut out glass listed under assistive equipment. This was referenced for use under medication administration, but not for mealtime. • In 22 of 24 PNMPs reviewed (92%), strategies for medication administration were included. Instructions did not consistently specify position or head alignment. • In 22 of 24 PNMPs reviewed (92%), strategies for oral hygiene were included. Instructions did not consistently specify position or head alignment. • 24 of 24 PNMPs (100%) reviewed included a heading related to communication, though the information included was very inconsistent in content and detail. In three cases (Individual #477, Individual #469 and Individual #328), there was reference to the communication dictionary only. In other plans, there were no descriptions or limited descriptions related to expressive and receptive communication or strategies that staff could use to interact with the individual.	

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		Standard: PNM plans were incorporated into individual's Personal Support Plans. None of the PSPs submitted (24/24) for the individuals included in the sample selected by the monitoring team were of the new format. In the old format, recommendations from discipline specific assessments were listed in the assessment portion of the PSP, including OT/PT, Nutrition, Speech, Medical, and Nursing, among others. There was generally a statement in the General Discussion section indicating only that the PNMP was reviewed, but the specific strategies were not specified. If changes were required, it was not apparent that the team had considered the issues and made active decisions about the necessary modifications to the plan. There was no clear link between the interventions in the plan and the individual's health risk indicators or needs. Habilitation Therapies or Nutrition Services representation, as evidenced by signatures on the sign in sheet by OT, PT, or SLP, was absent for the PSP meetings in the 24 (0%) records reviewed. In five cases, a PNMP coordinator attended the meeting, but as a paraprofessional they were not able to contribute to the meetings related to clinical information, questions, or team decisions There was no clear evidence that the PST understood and considered the interrelationship between the risk issues the individual had or the effectiveness of the supports the PNMP provided in mitigating risks to an individual's health and safety. As an aspect of another document request, current PSPs for three individuals were submitted in the new PSP format. This included Individual #518, Individual #321, and Individual #143. An OT assistant attended two of these three PSPs with no other representation by Habilitation Therapies. A dietitian also attended two of the three PSPs. Again, the focus of supports in the PNMP did not correlate with the identified by the PST risk issues. For example: • Individual #143: The PST identified that she was at high risk for fractures and medium risk for aspiration, constipation, GI concerns, osteoporosis, and challenging behaviors. The PSP stated that these were being addressed via medications and nursing care plans, but did not refer to the PNMP. A separate section of the plan referred to the PNMP with a stated focus of maintaining skin integrity, assisted mobility, and good nutritional status. There was no evidence that the plan had been designed to reduce or mitigate health risks identified by the PST and consistent with the PSP. There was no evidence of review of the PNMP by the PST for appropriateness or effectiveness. There was a service objective for implementation of the PNMP, but there were no specific or measurable outcomes outlined. • Individual #321: The PST identified that she was at medium risk for GI concerns, osteoporosis, and challenging behaviors. The PSP identified that these were addressed via medication and a BSP. The section referring to the PNMP merely	

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		listed her assistive equipment. There was no evidence of review of the PNMP by the PST for appropriateness or effectiveness. There was a service objective for implementation of the PNMP, but there were no specific or measurable outcomes outlined. • Individual #518: The PST identified that she was at medium risk for aspiration pneumonia. Other concerns were not rated, but included skin integrity and risk of injury and osteoporosis. The PNMP was more closely linked to the risk issues identified for Individual #518 and included skin integrity and aspiration. The PSP merely listed the equipment provided, but no specific strategies. There was no evidence of review of the PNMP by the PST for appropriateness or effectiveness. There was a service objective for implementation of the PNMP but there were no specific or measurable outcomes outlined. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** Individuals who had received PNM supports were reviewed 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, nutrition and SLP assessment reports. Unfortunately, as stated above, therapy and nutrition services representation at the PSP meetings was poor and, as such, would impact the collaborative development of the PNMP. There was no evidence of PST discussion of the elements of the plan, its effectiveness, or need for modification, but only a statement that the plan was reviewed. The PSP process had been revised and implementation was evolving at the time of this review. The PSTs were struggling with integration of the new PSP process and the new risk assessment process. Further assessment of this element will be required during the next review when these two systems are more familiar to the staff and well established. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.** There was evidence in each of the annual OT/PT assessments that the PNMPs were reviewed and recommendations for changes were made at that time as indicated. In addition, most individuals had multiple revisions throughout the year. In the General Discussion Record of the PSP, there was generally a section that included a PNMP heading. There was generally a statement that the PNMP had been reviewed but there was no outline of the strategies, or an indication if the plan was accurate or effective, and it did not connect the elements of the plan with the identified health risks. Again, as stated above, without consistent attendance by the therapy staff at the PSP meetings,	

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		comprehensive discussion and review of the plans in relation to the risk elements identified by the PST at that time would not be effective.	
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.** PNMPs and Dining Plans were developed by the therapy clinicians. Generally, the PNMP was located in a notebook in the back of an individual's wheelchair if he or she had one, or nearby, otherwise. In most cases, pictures were available with the PNMPs related to wheelchair and bed positioning, mealtime positioning, and the use of orthotics or braces. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs. Wheelchair positioning instructions were generally not specific in the PNMPs, but greater detail was generally included in the instructional plans. Limited instructions in the PNMP 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, but not specified in the PNMPs. In some cases, this was noted in the individual instructional plans along with the photos. Dining Plans were noted to be consistently available in the dining areas. Staff were observed to read the plan when asked a question, though reference to the plan before beginning the meal was inconsistent. In some cases where an error was noted by the monitoring team, the staff was asked to read the plan. They were also inconsistently able to recognize the error observed. Based on observations of individuals during meals across a variety of homes, a number of errors were noted in staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP. Some examples are presented below: • Individual #319: His dining plan had been previously developed by an OTR who was no longer employed at MSSLC. Though the plan was current within the last 12 months (4/10/10), there was no evidence that the current OTR had reviewed the plan and concurred with the strategies outlined in the plan. • Individual #99: His plan stated that staff should only fill his glass ¼ full, but his glass was full. • Individual #502: His plan stated that staff should only fill his glass ¼ full, but his glass was nearly half full. Staff added a full packet of sugar to that small amount of fluid before serving it to Individual #502. • Individual #94: His plan stated that staff should only fill his glass ¼ full, but his	Noncompliance

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		glass was filled with a four-ounce container of tomato juice. • Individual #494: She was observed taking large bites. There were no staff monitoring her. Individual #494 had experience choking events in the last year. • Individual #108: Familiar staff were to sit with her, per her Dining Plan. There were no staff assigned to sit with her. Her plan was dated 8/6/09 and had been written by an OTR who was no longer employed at MSSLC. There was no evidence that this plan had been reviewed or updated since that time. • Individual #477: Her dining plan indicated that she should have honey-thickened liquids. By report, there was no pre-thickened honey-thick fluids available in the home, so staff had to prepare the liquids before serving it to her. The staff person was observed to thicken a large container of fluid with Simply Thick gel. The fluid was offered to her and she drank a full glass without intervention by staff. The monitoring team noted that the liquid was not honey thick and questioned the staff how the beverage had been prepared. She reported that she used four packets of thickener in 28 ounces of liquid. Per the package instructions she should have used seven packets instead. The PNMPC present at the meal did not intervene or notice the error. • Individual #432: She was to be served honey-thick liquids. While she had not yet been served, she would have likely received the same improperly prepared liquids as Individual #477 above because they sat together at the same table, had the monitor not intervened. • Individual #469: His plan stated that staff should only fill his glass ¼ full, but his glass was full. The staff assisting him did not intervene. When asked, she responded that someone else had prepared the glass. This direct support staff did not make the correction until prompted to do so. The dining plan also indicated that he should alternate bites with sips of fluid. This was not observed. He had also been served pie and the crust had not been cut up into half-inch pieces consistent with a chopped diet. The pie had to be returned to the kitchen because staff reported that they were not permitted to modify or make corrections to any food in the home. • Individual #60: He had been served pie and the crust had not been cut up into half-inch pieces consistent with a chopped diet. The staff had to be prompted to make the correction to the diet texture per his dining plan. The pie had to be returned to the kitchen because staff reported that they were not permitted to modify or make corrections to any food in the home. Individual #60 became extremely upset that staff had to remove his pie, but calmed as soon as it was returned about 10 minutes later. • Individual #427: His dining plan was dated 3/24/09, not current within the last 12 months, and nearly two years old with no evidence of review. The monitor asked the OTR present why it had not been updated and she reported that the	

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		plan needed new pictures of head support. She indicated that the pictures had been taken just two weeks ago and yet the plan was still not updated at the time of this onsite review. • Individual #128: He was drinking from a paper cup. When asked about this staff reported that they do not always get enough glasses from the kitchen and then substitute with a paper cup. • Individual #84: The nurse used a plastic spoon to present her liquids with medication administration. She indicated that this was acceptable. • Individual #272**:** The nurse was observed to take honey-thickened liquids and thin it down with water to offer to Individual #272 who received regular fluids • The nurse was observed to place leftover crushed medications, due to refusal by one individual, on the medication cart with one bite left in the cup. She was observed to also place prepared medications for two other individuals on the cart because they were not ready for their medications. • Individual #304: Staff was observed offering her nectar thick liquids by spoon, though this was not indicated in her Dining Plan. When asked about this, staff reported that they did it to prevent aspiration. • Individual #29: Her food was prepared and sat on the table for over 10 minutes before she was brought to the table. The staff was preparing her liquids. She was prompted by the QA monitor to get a fresh tray. • In Martin 7 and 8, staff reported that no extra regular spoons sent from the kitchen, so they had to use plastic spoons for beverages. They reported that this occurred regularly. **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. A few staff were able to verbalize the rationale for specific strategies they were using as directed in the PNMP and/or Dining Plan, however, many did not appear confident. As described above, there were a number of errors in implementation suggesting that staff did not fully understand the importance of these plans and the risks presented by the individuals they served. In one case as described above, a staff person understood that the diet texture presented was incorrect when it was brought to his attention, however, he did not seem to understand that he needed to make a correction regardless of his concern that the individual would become upset with the interruption. This situation further emphasized the importance of a check and balance to ensure that the individual get the food and fluid consistent with the diet order prior to serving to prevent undue stress on the individual when a correction must be made during the meal to ensure safety. There is a delicate balance and staff must be diligent to ensure accuracy at all levels of service from kitchen	

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		preparation to the servers in the home and to the assistants at the table with an individual.	
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.** Per the documentation submitted, staff training for New Employee Orientation related to PNM included body mechanics, lifting and transfers (stand pivot, two person, mechanical lift), PNM monitoring, the PNMP, positioning, instructional plans (communication devices, communication dictionary), gait belt, pressure ulcers, general wheelchair guidelines, wheelchair cushions, use of mechanical lift, Geo mattresses, and functional dining. There were no skills-based checklists for these. A written test was submitted used to establish competency. Skills-based performance was monitored by the PNMPCs after the new staff were assigned to a home. **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.** No competency-based training checklists were submitted as used for NEO staff training in the area of PNM. By report, a recently implemented system involved the PNMPCs providing monitoring and coaching of new staff once they were assigned to a specific home. If they were not able to demonstrate sufficient competency, the new staff would be required to repeat NEO training for PNM. After 30 days, if staff were still unable to demonstrate competency, they were to be re-assigned to a living area with a different level of care. By report, inservice training for direct support staff required verbal and/or return demonstration. Licensed professional staff conducted inservice for available staff on first and second shift, then home managers were required to complete the training for other staff, 10-6 shift, and float staff. There was no mechanism to ensure that home managers provided the same level of training to ensure consistency and competency of all staff. Further review of progress in this area will occur during subsequent onsite reviews by the monitoring team. Dining plan training rosters were submitted representing training for 663 staff. The method used to establish staff competency was as follows: • Demonstration: 1/663 (less than 1%) • Verbal: 160/663 (24%) • No designation: 491/663 (74%) • Passing a verbal quiz: 11/663 (2%) Other than pass designations with a verbal quiz, there were no specific competencies stated in the training. The newest form required the trainer to designate what skills were	Noncompliance

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		demonstrated, what questions were answered or, in the case of a written test, the test was attached. The staff's signature on the roster indicated that he or she attended and then a pass/fail grade was assigned for each participant. Future staff training was to be in this format. Further assessment of the implementation of this system will be necessary during subsequent reviews by the monitoring team. In the case of Individual #72, he sustained a serious fracture to his left humerus on or around 12/1/10 to 12/3/10. Staff interviewed in the investigation admitted to using his arms to reposition him in bed. Using the extremities to move someone is not a generally accepted practice and is particularly contraindicated for an individual with osteoporosis as was the case for Individual #72. The COTA was reported to have said that staff were to use a sheet to reposition when the PNMP did not specify otherwise. She also indicated that some 10-6 staff may not have had the training taught in pre-service. The PNMP for Individual #72 did not specify any specialized means, but indicated that he repositioned himself and that staff should "handle with care" secondary to his fragile bones. There were no specific guidelines as to what "handle with care" meant, and there were no guidelines for staff in this regard. It was of significant concern that it was known that some staff may not have received the training and this had not been provided until after this incident. Staff training related to repositioning in bed noted on 12/10/10, 12/23/10, 2/15/11, 2/16/11, and 2/25/11 represented training provided to staff related to his PNMP for 33 staff related to the use of sheets and his PNMP. There was no evidence that any staff had demonstrated competence in performing these skills. On 2/16/11, 14 staff were trained regarding "what method of transfer is to be used and how many to assist?" All were listed as passed, but there was no indication that these staff had been required to demonstrate their competence with the transfer, but merely answer the question verbally. One individual had a verbal quiz regarding the elements of his PNMP on 2/25/11 and seven staff were designated as passing related to oral hygiene and medication administration though there was no evidence of skills-based competencies required. **Standard: All foundational trainings are updated annually.** Lifting and transfer training was updated annually after initial NEO training. It was reported, however, that CTD staff conducted that training rather than Habilitation Therapy staff and there was no evidence that those trainers had received competency-based training to provide adequate instruction in this area. Annual retraining curricula were not submitted for PNM.	

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		Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel. Initial staff training was conducted by Habilitation Therapies for available staff and PNMPCs. Subsequent training was conducted by PNMPCs and home managers. There was no mechanism to ensure that staff training occurred as outlined in the training plans when not conducted by Habilitation Therapies staff. As described above, individual-specific training was conducted by Habilitation Therapy staff across all areas of the PNMP. Documentation of the method used to establish staff competency was lacking in consistency. A new system had been implemented, but further review is indicated by the monitoring team in the future. Again, in the case of Individual #72, staff had offered him either pudding or applesauce on 2/23/11, though he was enterally nourished and was to receive nothing by mouth. This staff reported that they thought he was someone else. It was determined that this did not constitute neglect. It was of concern that this individual had not been adequately trained to look at the PNMP/MAR prior to assisting an individual to eat. The failure to do this or to provide training in this regard was seriously neglectful. **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 consistently competency-based, so while staff may have received some level of training for implementation of PNMPs for those at high risk, it was not generally performance-based, and did not require successful performance of clearly established competencies. Training was not consistently effective as evidenced by the 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.** There was no evidence that there was competency-based individual-specific training for staff before they worked with individuals who were at high risk or for pulled/float staff. Training for changes to plans were conducted by therapists, PNMPCs, and in some cases, by home managers. This training was not consistently documented and competency had not been clearly established.	

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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 related to the process of PNM 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 mealtime and snacks, bathing, medication administration, oral care transfers, and positioning. There was no mechanism to ensure that each of these areas was routinely monitored because the schedule was developed by the individual PNMPC and they kept their own records as to completion of the forms. There was limited oversight to track and trend their compliance with the intended frequency and scope of the monitoring conducted. 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. The monitoring sheets submitted were completed by the PNMPCs so it was not clear as to the frequency or consistency of the process for professional staff. **Standard: All members of the PNM team conduct monitoring.** The PNMT was not yet a functioning team. There was no system of routine review established to be conducted by the clinicians relative to the health status of those individuals at high risk who were followed by the PNMT. **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 system implemented to address monitoring by the PNMT at the time of this onsite review. There was no mechanism to analyze the information obtained by the PNMPCs and it would be difficult to track individual-specific issues through to resolution or to track and trend concerns noted in homes or across the facility. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** There was an expectation of immediate intervention when an individual was determined	Noncompliance

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		to be at risk of harm. There was a section at the bottom of the observation forms to circle concerns noted by the monitor. Concerns were circled for only six of the completed forms submitted for December 2010. Though the monitors identified issues during their observations, they rarely documented that they had notified anyone else of these issues. There continued to be a number of issues identified throughout this report that suggested the PNMPCs were insufficiently trained to consistently identify concerns that required attention by the therapists or the PNMT.	
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 monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	**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 new health risk assessment process and the new PNMT process were only recently implemented and further review during the next onsite visit will be necessary to determine the effectiveness of these systems. **Standard: Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.** Individuals with PNMPs were reviewed on an annual basis with changes in the interim, generally, indicated based on referral or the identification of a problem. Routine, proactive review of the plans was not conducted by the clinicians with frequency based on health risk level. In the case that an individual participated in direct therapy, progress notes were written, though very few individuals received this as discussed in section P below. There was no consistent link of the PNMP to health risk issues and there was no formal and consistent review of the plans relative to how well the plan addressed or minimized these concerns. Even during the annual assessments, the plans were reviewed in a more rote manner to continue a strategy with no clear review to measure or evaluate the actual efficacy of the plan to the issue itself. For example, there was no review to determine if strategies to address falls for an individual effectively resulted in a reduction from the previous period. There was no detailed comparative analysis of data or assessment findings. PNMP and Dining Plan monitoring were conducted by the PNMPCs and, as paraprofessionals, they would not be able to make judgments as to efficacy of the plans and to determine if there was a positive outcome related to PNM risks. Currently, there was no other system of monitoring of PNMP effectiveness for those at highest risk. As stated above, there was no routine documented review of the supports and services conducted by the licensed clinicians to address effectiveness for those at highest risk unless a problem had been identified and, as such, was reactive rather than proactive.	Noncompliance

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		A large number of completed monitoring forms were submitted for the last three months, as requested. Forms included were completed in December 2010, January 2011, February 2011, and, to date, in March 2011. There was no system established to analyze these extensive findings. Approximately 629 monitoring forms (those completed in December 2010) were selected for review and analysis by the monitoring team. Of those only one (1/629) had been completed by a licensed clinician (Pam Harlan COTA, PNMC Supervisor) and four (4/629) had been completed as a validation check of three different PNMPCs. Validation had also been conducted by Ms. Harlan. Approximately 174 (28%) of these forms were PNMP Observation Sheets. This was a general form used to observe an area rather than one specific individual. The other 455 (72%) forms completed in the sample were the Comprehensive Monitoring Form. Of these individual-specific monitoring forms, 65% did not identify any concerns as designated by a "yes" or "NA" response to a question. Approximately 38% of the forms identified noncompliance with implementation of the PNMP or a "no" response. The form indicated that "questions answered NO require a comment and notification of Hab. Therapy." Only 14 or 3% of those forms with a "no" response documented that the monitor had reported the identified concern to anyone. The majority of the forms (52.6%) were completed between the hours of 8:00 am - 4:00 pm. The established hours for the PNMPCs was 8:00 am – 5:00 pm and they were to stay late or come in early at least one time weekly to complete observations during the morning routine and breakfast or during the evening routine and meal. Only 10.6% were completed before 8:00 am or after 4:00 pm. Many of these did not specify AM or PM. Approximately 36.8% of the forms did not document the time of the monitoring at all. The PNMPCs indicated that they have asked direct support staff to adjust the bathing schedule, mealtime or other activities in order to complete the monitoring during their regular work hours or at a time that was more convenient for them. It was of significant concern that monitoring required that direct support staff to accommodate the monitor's schedule and that there was a very limited amount of monitoring that occurred outside 8:00 am and 4:00 pm, rather than providing a balanced representation of supports and services provided to an individual across the course of their day. There was no evidence of any monitoring that occurred during evening or nighttime hours.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an	**Standard: All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.** Per the documentation submitted, it was reported that enteral nutrition assessments had	Noncompliance

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	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.	been completed prior to the annual staffing by Jean Reboli, MS, CCC-SLP though it was reported that none had been completed since 1/1/11. It was of concern that this process had been completed by a single clinician rather than from an interdisciplinary team approach. As a result, previously completed evaluations were not reviewed and it would be necessary to re-assess each individual who received enteral nutrition in order to meet the standards of the Settlement Agreement. There was no evidence that the enteral nutrition assessment in the new format implemented statewide had been completed for anyone living at MSSLC at the time of this onsite review. This area will require further review during the next onsite visit. There were 35 individuals listed as receiving nutrition and hydration enterally. There was a new system as an aspect of the At Risk Individuals policy that provided a format for the annual review of those who received enteral nutrition by the PST using the Aspiration Pneumonia/Enteral Nutrition Evaluation, to be completed by 3/31/11. Evaluations completed since 1/1/11 with PSPs and Addendums were requested by the monitoring team. No completed evaluations were submitted, but rather a list of individuals who received enteral nutrition. As this process had just recently been implemented, further review will be conducted by the monitoring team in the future. **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 that included the same elements described above. Based on a review of 24 PSPs in the individual record sample, there were 13 who received their nutrition via gastrostomy tube and nothing by mouth. 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 oral feeding, a plan is in place that addresses the process to be used.** There was no protocol outlined for this process, however, as all individuals were provided a PNMP and Dining Plan, these elements would likely also be provided to an individual who transitioned back to oral intake, however, competency-based training was limited, so staff training may likely be limited. A draft protocol outlining therapeutic pathways for resuming oral intake for an individual who was enterally nourished had been developed for statewide review, but as yet had not been implemented.	

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		Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT). One aspect of the new At Risk Individuals policy, implemented as of 1/1/11, was an outline for an Aspiration Pneumonia/Enteral Nutrition Evaluation. This form was to be used for all individuals who were at high risk for aspiration pneumonia or who were hospitalized for aspiration pneumonia multiple times within the last year, as well as a means to conduct an annual assessment of individuals who received enteral nutrition. The assessment was to be compiled by the nursing case manager based on information provided by the PCP, nursing, Habilitation therapists, dietitian, pharmacist, and other members of the PST. No assessments completed were submitted as requested, so it was presumed that none had been completed at the time of this review, so further assessment will be necessary by the monitoring team in the future. **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. Further focus on these areas should occur as the At Risk and PNMT systems are implemented.	

Recommendations:

1. PNMT assessment and review should focus on PNM concerns with follow-up through to problem resolution. Set outcome measures with regard to reason for referral, specific risk indicators and timeframes for achievement. Interventions should support achievement of identified outcomes. The PNMT should continue to monitor until the individual attains and maintains at the goal level. Assessments should be new evaluations of the individuals referred that are collaborative and integrated with all PNMT members, not merely a review of previous discipline-specific assessments. This will be more difficult as the same staff clinicians also serve as the experts on the PNMT. It will be critical to view these individuals in a new manner in order to yield new information and new intervention plans for individuals who have been referred.

2. Identify a consistent RN member of the PNMT immediately.

3. It will be absolutely necessary that each team member is prepared with all of the information on each case reviewed. The PNMT should also view this process as an assessment and not merely a meeting. The initial meeting should involve the development of an action plan so that additional information may be gathered or that additional testing, trials or assessment can occur. When the PNMT reconvenes they would outline a plan to address the individual needs. Outcomes must be related to the issues that brought the individual to the attention of the team in the first place.

4. Develop a policy or, at least, comprehensive written guidelines, related to the monitoring system.

5. 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.

6. Conduct trend analysis of all monitoring data. Review findings and make system adjustments. It is critical to establish a mechanism to review the overall trends and findings to drive staff training in the homes and other settings in which the PNMP is implemented. This review is an important quality improvement element.

7. Consider a significant increase in nutritional staff. Two dietitians for the facility and then one only when the other is assigned to the PNMT was insufficient to adequately meet the needs of all individuals living at MSSLC (393 individuals).

8. Identify and address risk issues consistently in the focus of the PNMP and dining plans.

9. Ensure improved attendance at the PSPs and PSPAs by Habilitation Therapies and Nutrition Services staff. Attendance by the PNMT will also become critical as they begin to conduct assessments and develop intervention plans.

10. New therapy clinicians should review existing plans to determine if they concur with the plans as written. They become responsible for all aspects of the plans including errors and oversights and should be familiar with what those plans prescribe.

11. Consider permitting home staff to make corrections to food and fluid in specific instances preferably before, but during, serving, as needed, when an error is noted to ensure that the individual receives the prescribed food texture and liquid consistency. Requiring staff to return a piece of pie so the crust can be cut into smaller pieces, for example, is inconvenient and unnecessary and ultimately could become a deterrent to compliance with the plan. It is understood that major changes may not be practical, but clear guidelines should be established. Also provide an adequate number of extra glasses, bowls, spoons, and other equipment used for implementation of the Dining Plans. Some plans require duplicates and these were not readily available.

12. Review use of plastic spoons for medication administration as this may not be safe for all individuals.

13. Consider a change in the work schedules of the PNMPCS. Monitoring should occur at times throughout the day and in a manner that is the least disruptive to the individuals reviewed and not at the convenience of the monitors themselves.

14. Ensure that competency-based training is skills-based whenever indicated. Staff generally learn better by learning and trainers get a better idea of the effectiveness of their training through return demonstration rather than mere verbal responses.

15. Focus on training for aspiration trigger sheets. Staff were not able to locate the sheet for one individual and in another case the sheet had not been filled out consistently by nursing or direct support staff.

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 OT/PT Clinical Staff list, license numbers and caseloads list o Continuing Education documentation for clinical staff o MSSLC POI for Section P o MSSLC Organizational Charts o Staffing data (2/15/11) o Current Census Counts by Home (3/13/11) o List of new admissions o OT/PT/SLP Evaluation Update template (draft) o PNMPs submitted o PNMP list 2/11/11 o List of individuals receiving direct OT/PT services o PNM/OT/PT curriculum for NEO o Settlement Agreement Cross Referenced with ICF-MR Standards Section P template o Pressure Wounds list (2/15/11) o List of individuals with skin breakdown, decubitus ulcer o List of individuals with contractures o List of individuals with GERD o HST risk assessment ratings (2/16/11) o List of individuals with chronic and acute pain o List of falls in the last 12 months o List of individuals with osteoporosis/osteopenia o List of fractures o List of hospitalizations/ER visits o List of individuals who were non-ambulatory and assisted ambulation o List of individuals with wheelchairs as primary mobility o List of individuals with transport wheelchairs o List of individuals with assistive ambulation devices o List of individuals with orthotics and/or braces o List of individuals with decubitus/pressure ulcers during the past year o List of individuals who experienced a falling incident during the last three months o List of individuals with and without PNM needs o OT/PT Baseline Assessment/Baseline Update Assessment template o Completed PNMP Observation Sheets submitted o Completed Comprehensive Monitoring Forms submitted

	o Wheelchair Work Order Data Spreadsheet o Wheelchair Data Spreadsheet o Habilitation Services Wheelchair/Positioning Consultations submitted o PNM-related training rosters submitted o OT/PT Therapy Database o OT/PT assessments/updates, PSPs, PSPAs, treatment plans and documentation for: o Individual #548, Individual #451, Individual #521, Individual #455, Individual #361. o OT/PT evaluations/updates and PSPs/PSPAs for: • Individual #321, Individual #143, Individual #562, Individual #53, Individual #322, Individual #497, Individual #518, Individual #132, Individual #365, Individual #500, Individual #228, Individual #273, Individual #367, Individual #42, Individual #110. o OT/PT assessments, consultation reports, progress notes, PSPs and PSPAs for those receiving direct services: • Individual #277, Individual #338, Individual #197, Individual #197, Individual #293, Individual #132, Individual #557, Individual #328, Individual #16, Individual #72, Individual #444, Individual #160, Individual #172, Individual #304, Individual #395, Individual #80, Individual #321, Individual #120, Individual #467, Individual #154, Individual #143, Individual #528, Individual #301, Individual #303, Individual #302, Individual #376, Individual #427, Individual #188, Individual #291, Individual #175, Individual #178, Individual #518, Individual #43, Individual #441, Individual #248. o Full medical record for Individual #72 o PSPs, all PSPAs, PBSPs, Physician Annual Medical Reviews, Active Problem List, hospital records, Health risk Assessment Rating Tool, Integrated Progress Notes for 12 months, nursing assessments and quarterlies, documents in Habilitation tab of record, swallow studies, x-ray reports, nutrition assessments, notes and updates, PNMPs (12 months), Dining Plans (12 months), positioning instructions and pictures, orthotics plans and pictures, other Habilitation Therapy plans, communication plans (none submitted), communication dictionaries, monitoring checklists (three months), weight records/BMI (12 months), and communication-related assessments for: • Individual #435, Individual #40, Individual #38, Individual #542, Individual #79, Individual #293, Individual #477, Individual #143, Individual #285, Individual #369, Individual #188, Individual #321, Individual #432, Individual #494, Individual #469, Individual #567, Individual #328, Individual #518, Individual #151, Individual #503, Individual #257, Individual #16 and Individual #304. There was no evidence of communication assessments for Individual #542, Individual #257, or Individual #304 in the records submitted. <u>Interviews and Meetings Held</u>: o Brenda Howell, OTR, Habilitation Therapies Director o OTs and PTs o PNMP Coordinators o Various supervisors and direct support staff

	Observations Conducted: o Living areas o Dining rooms o Day Programs o PNM Clinic o Wheelchair Clinic
	Facility Self-Assessment: MSSLC's self-assessment identified compliance for item P1 of this provision, related to an adequate number of OTs, PTs, and other professionals. While the facility had provided new contract OTs and PTs (five PTs, four OTs, and one COTA) via the Guardian contract with the state, these staff were on a 13-week rotation and three of those weeks had already been spent in NEO orientation. Existing staff contracts were to be terminated as of 3/31/11. The Settlement Agreement provision requires that MSSLC shall ensure that individuals identified with therapy needs receive adequate and clinically justified assessments and that appropriate services be provided to those that require them. As most of these new staff had only recently begun their service at MSSLC, they had not yet had the opportunity to demonstrate competence in these areas. No evidence of their work was submitted in the document request materials. Thus, the monitoring team considers this element to not be in compliance at this time. It will be critical that the facility address the issues of a need for an extended new employee orientation and the fact that the Guardian staff would potentially be short-term only. Significant considerations for longer term retention of staff should be a major focus as well as a well-organized and comprehensive orientation for the department and opportunities for ongoing continuing education and clinical instruction. The self-assessment was consistent with the monitoring team's assessment of noncompliance with the other items of this provision. Progress identified by the facility was not addressed in manner that outlined each of the action steps necessary to meet the provision items. The approach used for the recommendations would likely be more useful to identify what needed to be done in measurable terms and then provide statements and evidence to demonstrate completion of the interim steps.
	Summary of Monitor's Assessment: The Habilitation Therapies department was dealing with significant issues of transition and instability in the wake of large caseloads and the expectations related to the Settlement Agreement. There was a new department director, existing staff were scheduled to be transitioning out, and new staff were transitioning in. There was limited change noted since the previous review regarding the requirements of the items of this provision. Systems had not been modified in any essential manner. The assessment process had changed very little from the previous review. There continued to be no training objectives and the interventions provided by OT and PT were still not integrated into the PSP. There continued to be no clearly established

	link between the health risk indicators identified by the PSTs with the PNMPs. Monitoring was not clearly driven by level of risk. The PNMPCs required more training and oversight in order to ensure that monitoring provided the appropriate data to evaluate the efficacy of person-specific plans as well as the training provided to staff related to implementation of PNM. There had not been any system of trend analysis established to date.

#	Provision	Assessment of Status	Compliance
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 Habilitation Therapies Department had a new Director Brenda Howell, OTR/L, employed since November 2010. OT and PT staffing levels were significantly increased from the previous onsite review. Current staffing included a full-time PT who had previously been employed and served as interim department director (Sandra Opersteny, PT, currently serving as the Assistant Director). There were two vacant state PT positions as of 2/15/11. Contract staff at the time of this review included Sandy Leggett, PT, and Arthur Norton, PT, who were both providing services during the previous review. Five new PTs were selected via the state contract with Guardian and were to fulfill 13-week assignments at MSSLC. Options for extensions were not known at the time of this review. There were two PTAs (Cynthia Buchmeyer, PTA, and Betty Cotton, PTA) and one PT technician (Lois Henry). There was one full-time OT who was employed previously (Doris Ricketts, OTR/L, MBA). There were three vacant state OT positions as of 2/15/11. Four additional OTs were selected via the state contract with Guardian and also were hired to fulfill 13-week assignments at MSSLC. There were four COTAs (Victoria Lee, Lisa Finley, Pam Harlan, and Karen Fleming) one of whom served as the PNMP Coordinator supervisor (Pam Harlan, COTA/L) and one OT technician (Lisa Maynard). An additional COTA was provided via the contract with Guardian. There were 12 staff who served as PNMP Coordinators. Each of the new contract staff had recently begun at MSSLC and had completed three weeks in new employee orientation. There was no formal orientation to the department, but the clinicians had participated in a four hour overview with Sandra Opersteny, PT, to review basic procedures and expectations. There was a plan to formalize this process per Brenda Howell, OTR/L, Director. Evidence of licensure for the new clinicians or CVs for any OT/PT staff were not submitted. CVs submitted for the Director Brenda Howell, OTR and Assistant Director Sandra Opersteny, PT, were submitted and reviewed in section O above. Continuing education records were submitted with participation as follows: Lisa Finley, COTA	Noncompliance

#	Provision	Assessment of Status	Compliance
		• 20th Annual Habilitation Therapies Conference (12.0 contact hours), 9/20-21/10 Victoria Lee, COTA • 20th Annual Habilitation Therapies Conference (12.0 contact hours), 9/20-21/10 Betty Cotton, PTA • 20th Annual Habilitation Therapies Conference (1.2 CEUs), 9/20-21/10 Sandy Leggett, PT • 20th Annual Habilitation Therapies Conference (1.2 CEUs), 9/20-21/10 • Ethics in PT (.2 CEUs), 1/7/11 • Dementia Outside the Box (.6 CEUs), 12/10/10 • Dementia Management Advanced Skills for the Healthcare Practitioner (.6 CEU), 11/1/10 There was no evidence of continuing education or clinical instruction in the last six months for any other OT/PT staff. Other existing staff listed continuing education for the six month period prior to the last review in September 2010 with one exception. Doris Rickets, OTR, MBA, had no hours listed for the last review and none again during this last six months period. Regardless of experience, it is critical that all therapy clinicians routinely participate in continuing education and clinical instruction routinely in order to remain current with regard to assessment and intervention. Fabrication of seating systems continued to occur onsite with additional support via a local vendor. There were four technicians who served as fabricators and conducted maintenance work on equipment. A durable medical equipment vendor with ATP certification participated in seating system assessment design and fittings. Fabricators were responsible for collaborating with therapy clinicians and the ATP to design seating systems for individuals living at MSSLC, fabricating custom components, and completing repairs and modifications. There were 12 Physical Nutritional Management Plan Coordinators (PNMPCs) supervised by Pam Harlan, COTA/L. There had been some interruption in service due to medical leave for some of these staff since the previous onsite review. Based on a list of PNM needs submitted, 216 individuals or 55% of the current census (393) were identified as requiring PNM supports and were provided a PNMP. All others were listed without PNM needs. Based on the reported census and identified PNM needs, as currently staffed, the OT and PT caseload sizes were significantly improved at 98 for the general census or 54 for those reported with PNM needs. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseload, with additional supports available from the	

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		therapy assistants. Annual assessments/updates were completed by OT and PT collaboratively. Those who did not have established PNM needs would likely require occasional supports to address acute injuries or to address more chronic conditions associated with aging for some individuals over time. Many others would likely benefit from skill acquisition/enhancement programs related to movement and mobility, as well as fine motor skills and independence with activities of daily living that were not identified or addressed at this time. Based on this review, however, a very limited number of these individuals were provided with OT or PT services beyond the PNMP. With the staffing limitations as reported in previous reviews by the monitoring team, capacity for expanded supports and services was difficult. Now with the improved staffing ration, this capacity should be significantly improved, however, the existing assessments generally only included recommendations related to the PNMP; additional needs had not been adequately identified for many individuals. The monitoring team requested that the five most current assessments completed by each therapist with the associated PSPs be submitted. OT/PT assessments were submitted for the following individuals: Individual #321, Individual #143, Individual #562, Individual #53, Individual #322, Individual #497, Individual #518, Individual #132, Individual #365, Individual #500, Individual #228, Individual #273, Individual #367, Individual #42, and Individual #110. Individual records were also requested for a sample of 24 individuals and assessments were submitted as follows for: Individual #293, Individual #72, Individual #477, Individual #38, Individual #79, Individual #304, Individual #369, Individual #151, Individual #328, Individual #567, Individual #16, Individual #542, Individual #188, Individual #432, Individual #285, Individual #567, Individual #143, Individual #518, Individual #494, Individual #321, Individual #40, Individual #503, Individual #435, Individual #257, and Individual #469. Based on review of the assessments submitted, there were at least 27 out of 36 (75%) individuals with identified concerns related to movement, mobility, range of motion, limitations in levels of independence, and/or regression of functional skills. Only four individuals for whom assessments were submitted had no reported concerns related to movement or mobility. Each of these was newly admitted to MSSLC at the time of their assessment (Individual #42, Individual #367, Individual #273 and Individual #132). Five others had mild to moderate issues reported. None of the individuals were recommended for direct OT services. Direct PT services were recommended for only three individuals including: Individual #321 to monitor her tolerance for a right knee brace; Individual #132 for moist heat, neck and trunk exercises, and shoulder strengthening; and Individual #477 for range of motion for hip and knee extension bilaterally. Interestingly, Individual #132 was not identified with any movement or mobility concerns in the assessment dated	

#	Provision	Assessment of Status	Compliance
		1/10/11 and there was no justification for the recommendation for direct physical therapy in this report. Individual #477 and four others were also recommended for walking clinic (Individual #72, Individual #16, Individual #293 and Individual #143). Others were recommended for a variety of indirect services via the PNMP and the provision of assistive equipment and/or orthotics. A list submitted to identify those who had received direct OT or PT services in the last six months was titled "PT Services for September 2010 to March 2011" and identified 36 individuals. There was no such list for OT services. It was presumed by the monitoring team that no one had received OT services during that time. Most of the individuals listed were involved in the walking clinic conducted by the PT assistants (25). Others were involved in range of motion, stretching or use of orthotics or braces (10). Individual #441 was treated for an injury to his right hand, Individual #395 was treated related to sitting tolerance and Individual #132 received treatment to strengthen core muscles, cervical spine, and shoulders. The POI reported that three individuals had received acute care intervention by OT. It further reported that 26 individuals participated in the PT walking maintenance program, 10 received training for "flexibility" by PT, and 12 others had received acute care intervention by PT. The list of PT services submitted did not identify acute care intervention for 12 individuals as reported in the POI, but rather for only one (Individual #441). Assessments for the individuals who were listed as receiving direct PT services based on the list described above were requested by the monitoring team. Submissions included the following: Individual #277, Individual #338, Individual #197, Individual #197, Individual #293, Individual #132, Individual #557, Individual #328, Individual #16, Individual #72, Individual #444, Individual #160, Individual #172, Individual #304, Individual #395, Individual #80, Individual #321, Individual #120, Individual #467, Individual #154, Individual #143, Individual #528, Individual #301, Individual #303, Individual #302, Individual #376, Individual #427, Individual #188, Individual #291, Individual #175, Individual #178, Individual #518, Individual #43, Individual #441 and Individual #248. The evaluation for Individual #160 was incomplete per copy submitted (page 5, containing the recommendations, was missing). No assessment was submitted for Individual #481 as requested. This assessment was not current. The assessment for Individual #175 was dated 12/15/09. Though she was identified as receiving therapy services, there was no evidence of a more current assessment. This assessment was also not included in the sample. Based on review of these additional assessments 31/32 (97%) presented with deficits related to movement, mobility, range of motion, independence and/or functional skills. Per the assessments submitted, recommendations for OT or PT intervention were as follows:	

#	Provision	Assessment of Status	Compliance
		• Walking Clinic (Individual #277, Individual #376, Individual #154, Individual #80, Individual #172, Individual #444, Individual #557, Individual #72, Individual #16, Individual #293 and Individual #143) • PT monitoring transfers/braces (Individual #304, Individual #321) • OT monitoring splints (Individual #328) • PT monitoring braces (Individual #328) • PT apply knee braces (Individual #427) • PT intervention for range of motion and sitting tolerance (Individual #395) • PT intervention for cervical range of motion (Individual #338) • PT intervention for moist heat, neck exercises, trunk exercises and shoulder strengthening (Individual #132) There were no recommendations for OT or PT as follows: • No OT recommendations (Individual #291, Individual #518, Individual #197, Individual #441, Individual #188, Individual #120, Individual #43, Individual #248, Individual #467, Individual #301, Individual #528, Individual #303, Individual #304, Individual #197**,** Individual #302, Individual #395, Individual #321, Individual #427, Individual #338) • No PT recommendations (Individual #291, Individual #518, Individual #197, Individual #441, Individual #188, Individual #120, Individual #43, Individual #248, Individual #467, Individual #301, Individual #528, Individual #303**,** Individual #197**,** Individual #302) **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** Assessments were completed as a more discrete measure of status rather than screenings, for most individuals. The assessments submitted were completed by both OT and PT. An assessment was submitted for each of the 24 individuals in the sample for whom personal records were requested as well as for an additional 37 individuals. Twenty of the most current assessments were identified as baseline, five were identified as updates, 12 were identified as baseline updates, and 24 were identified as comprehensive. Assessments for all but 10 individuals had been completed since the previous review in September 2010. There were 17 individuals listed as admitted since the previous review through 1/5/11. Assessments for five of these individuals were submitted and included Individual #110, Individual #42, Individual #367, Individual #273 and Individual #132. Each (100%) had been completed well within 30 days of admission. This was reported to be a consistent practice.	

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		Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification. By report, new issues that required additional assessment by OT or PT were generally addressed well within the 30-day period. There was no formal system to track specific referrals generated by the PST or via PNMP monitoring through to resolution. Based on the documentation submitted, 67 out of 72 (93%) of individuals had a current OT/PT assessment within the last year. Update assessments for Individual #257 (9/29/09) and for Individual #469 (9/28/09) had been completed 18 months ago, despite evidence of PNMPs and other supports. Individual #175's update assessment, dated 12/15/09, had been completed 15 months ago, though she was seated in a wheelchair, and required assistance from staff for mobility and for personal care via her PNMP. Additional discipline-specific consultations were completed per referral for specific issues. While the Settlement Agreement indicated that assessment should occur within 30 days of the identified need, this standard was not acceptable when there were urgent issues with potential for further injury or health and safety risks. Most of these appeared to have been completed in a timely manner. **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.** Per the clinicians, all individuals received an OT/PT assessment on an annual basis if they had required OT/PT supports or services during the previous year. These were identified either a comprehensive evaluation, baseline, or update. The most current assessment formats included a baseline and baseline update. These were identical and it was unclear why one was to be considered an update while another was considered to be a comprehensive evaluation. A plan to provide a comprehensive assessment every three years with an update in the interim years for those who received supports and services was in place. The monitoring team requested that the five most current assessments completed by each therapist with the associated PSPs be submitted. OT/PT assessments were submitted for the following individuals: Baseline • Individual #321 (1/21/11) • Individual #143 (1/25/11)	

#	Provision	Assessment of Status	Compliance
		Baseline Update • Individual #562 (1/21/11) • Individual #53 (1/27/11) • Individual #322 (1/14/11) • Individual #497 (1/21/11) • Individual #518 (1/21/11) • Individual #132 (1/3/11) • Individual #365 (1/6/11) • Individual #500 (1/7/11) • Individual #228 (1/7/11) Comprehensive Evaluation • Individual #273 (11/23/10) • Individual #367 (12/13/10) • Individual #42 (10/9/10) • Individual #110 (10/4/10) PSPs for these individuals were also requested and all were received. Nine of these had been completed from 1/20/10 to 2/24/10. No more current PSPs had been submitted for those individuals because they were likely not yet available at the time of this document request. All other PSPs submitted were current as submitted. Individual records were also requested for a sample of 24 individuals and assessments were submitted as follows for: OT/PT Comprehensive Evaluation • Individual #293 (10/18/10) • Individual #72 (10/12/10) • Individual #477 (9/23/10) • Individual #38 (11/2/10) • Individual #79 (10/12/10) • Individual #304 (8/30/10) • Individual #369 (8/4/10) • Individual #151 (10/20/10) • Individual #328 (8/19/10) • Individual #567 (11/12/10) • Individual #16 (9/2/10) OT/PT Baseline	

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		• Individual #542 (4/16/10) • Individual #188 (7/2/10) • Individual #432 (4/27/10) • Individual #285 (4/9/10) • Individual #567 (10/27/09) • Individual #143 (1/25/11) • Individual #518 (1/29/10) • Individual #494 (8/17/10) • Individual #321 (1/27/10) • Individual #40 (7/29/08) • Individual #503 (6/7/10) • Individual #435 (4/26/10) Update • Individual #257 (9/17/09) • Individual #469 (8/18/09) • Individual #40 (7/30/10) • Individual #494 (9/1/09) Baseline Update • Individual #518 (1/21/11) A baseline assessment for Individual #321 dated 1/21/11 was submitted with a different request, but was not present in her personal record. Current annual PSPs were submitted for 24 out of 24 individuals included in the sample, with addendums also submitted as present in the individual records. Documentation for those who received PT services was requested by the monitoring team. The list "PT Services for September 2010 to March 2011" provided identified 36 individuals. PSPs, PSPAs, OT/PT assessments, consultation reports and documentation since September 2010 were requested for each and reviewed as submitted. No list of individuals receiving OT services was submitted. Assessments were submitted as follows: Comprehensive Evaluation • Individual #277 (11/15/10) • Individual #338 (11/16/10) • Individual #197 (7/29/10) • Individual #197 (9/27/10) • Individual #293 (10/18/10) • Individual #132 (1/3/11)	

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		• Individual #557 (10/15/10) • Individual #328 (7/9/10) • Individual #16 (9/2/10) • Individual #72 (10/12/10) • Individual #444 (10/15/10) • Individual #160 (10/21/10) • Individual #172 (9/3/10) • Individual #304 (8/30/10) Baseline Evaluation • Individual #395 (6/3/10) • Individual #80 (5/28/10) • Individual #321 (1/21/11) • Individual #120 (5/7/10) • Individual #467 (4/9/10) • Individual #154 (4/23/10) • Individual #143 (1/25/11) • Individual #528 (4/2/10) • Individual #301 (5/21/10) • Individual #303 (2/11/11) • Individual #302 (7/2/10) • Individual #376 (7/23/10) • Individual #427 (2/7/11) • Individual #188 (7/2/10) • Individual #291 (6/11/10) Update • Individual #175 (12/15/09) • Individual #178 (8/4/09) Baseline Update • Individual #518 (1/21/11) • Individual #43 (2/14/11) • Individual #441 (1/14/11) • Individual #248 (2/7/11) As stated above, there were two individuals included in the sample reviewed who did not have current baseline assessments or updates within the last 12 months, though they had received supports and services related to OT and PT. As described above, updates for	

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		Individual #257 (9/29/09), Individual #469 (9/28/09), and Individual #175 (12/15/09) had been completed over 12 months ago in spite of the provision of OT/PT-related supports and services. There was no evidence of a more current assessment for these individuals. There was no assessment submitted for Individual #481, though she was reported to have been provided therapy supports in the last year. Other assessments submitted had been completed in the last 12 months and, as such, would be considered current. The updates generally made reference to a previous baseline report, but the baselines were not maintained in the personal records with the updates. In some cases, the baseline had been less than 12 months earlier, yet an update had been completed. It was not clear why this was done. Some examples included: • Individual #518 had a baseline assessment on 11/29/10 yet, less than two months later, a baseline update had been completed, on 1/21/11. There was nothing in the report to indicate that this was due to a change in status. The baseline assessment was not present in the individual record. • Individual #494 had a baseline assessment on 6/28/10 yet, less than two months later, another baseline was completed on 8/17/10. There was nothing in the report to indicate that this was due to a change in status. The first baseline assessment was not present in the individual record. • Individual #53 had a baseline assessment on 12/13/10 yet, just over one month later, a baseline update was completed on 1/27/11. There was nothing in the report to indicate that this was due to a change in status. The baseline assessment was not present in the individual record. • Individual #321 had a baseline assessment on 11/19/10 and, less than two months, later another baseline was completed on 1/21/11. There was nothing in the report to indicate that this was due to a change in status. The first baseline assessment was not present in the individual record. • Individual #322 had a baseline assessment on 11/22/10, yet less than two months later a baseline update was completed on 1/14/11. There was nothing in the report to indicate that this was due to a change in status. The baseline assessment was not present in the individual record. • Individual #228 had a baseline assessment on 1/2/11. A baseline update was dated 1/7/11. It was unclear as to the type of assessment provided and when it occurred. The baseline assessment was not present in the individual record. In another case, Individual #500 had received a baseline assessment on 2/2/09, yet he had not received a subsequent update until 1/7/11, nearly two years later. Only the update was present in his individual record. Individual #500 had a PNMP and had received PT services for walker use in September 2010. Individual #365 received a baseline assessment on 2/2/10 and again 1/6/11. There was no indication that this was due to a change in status. Only the most current baseline was present in his individual	

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		record. The baseline/ baseline update assessment format was submitted. Health risk issues were not addressed and was evident in the assessments submitted. Recommendations for supports were not linked to the specific health risks identified by the PSTs for each individual. There continued to be no focus on skill acquisition via functional outcomes and training objectives (SPOs) for those who would benefit. Each of the assessments had been completed prior to the PSP staffing date, though some only a day or two before. The most recent OT/PT Comprehensive Evaluations and Updates included the following sub-headings: General Information • Information • Diagnosis/Active Problems/Pertinent History • Precautions • Medications • Method of Communication • Vision/Hearing • Behavioral Considerations • OT consults/Acute Care/Monitoring • PT consults/Acute Care/Monitoring • Falls/Injury Information Motor/Functional Evaluation/PNMP • Physical Management Information • Respiration • Reflexive • Posture/Orthopedic abnormalities • Upper extremity range of motion • Lower extremity range of motion • Cervical (neck) range of motion • Upper extremity muscle tone/strength • Lower extremity muscle tone/strength • Balance • Gait/Mobility/Locomotion • Positioning • Wheelchair • Handling/Transferring • Sensorimotor Function	

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		• Fine Motor Function • Gross Motor Function • Activities of Daily Living Skin Integrity Oral Motor/ Eating Ability/Nutritional Management • Nutritional Management Information • Physical/Positioning Considerations • Oral Motor/ Eating Skills Assistive/ Supportive Devices • Wheelchair • Feeding Equipment • Gaitbelt • Walker • Braces • Ankle Foot Orthoses • Compression socks/hose • Orthopedic shoes/foot wear • Insoles • Helmets • Mattress Recommendations Each of the assessments reviewed contained most of these same headings and, as such, addressed movement, mobility, range of motion, independence, and functional status. The clinicians did not generally document functional examples of systems level findings, such as range of motion, strength, and muscle tone. Observation of activities outside of the clinic setting was not documented. This limited the clinicians' ability to identify potential for skill acquisition and therapy consultation for program development in these areas. During an observation of a PNMP clinic, when an assessment for Individual #291 was conducted, the PT indicated that a different PT had observed the individual in her home, but not in the day program areas. The clinic assessment was intended to capture the information that the other PT had not obtained. None of the clinicians could describe what Individual #291 did during her day program. When asked by the monitoring team, the clinicians reported that the standard head of bed elevation was 30 degrees; they did not know what elevation Individual #291's bed was set at, however. The OT was observed to question staff about the individual's participation in daily self-care and dressing activities. The OT reported that she had not conducted any observations in the home or day program areas at that time, but planned to do so later. Changes to the PNMP and recommendations were discussed during this PNMP clinic without this valuable information and it was highly questionable that these observations were conducted on a	

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		routine basis. Assessment of fine motor skills was not observed by the monitoring team during the assessment for Individual #291 during this onsite review. The following paragraph, or one very similar, was included in approximately 50% of the assessments: Fine motor skills were sufficient to retrieve, place, combine, manipulate and use objects functionally. A variety of full hand grasps and pinch patterns appropriate to task were demonstrated. Hand skills of reach, grasp and release were essentially intact. In-hand manipulation skills were intact for proximal to distal and distal to proximal. Bimanual function was normal. There were no specific data or observations reported to illustrate these statements and the adequacy of the assessments in this area was questionable. Fine motor or hand function was not addressed in nearly 30% of the assessments reviewed. Gait and gross motor skills were generally addressed in a more comprehensive manner though descriptions and analysis should be more functionally-based. Additional concerns noted in the assessment reports reviewed included: • There was no discussion of potential for skill acquisition across a variety of areas, including eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • In many cases, clinical information was merely reported, but was not utilized to guide decisions regarding intervention. • In the cases that therapy supports had been provided, there was no assessment as to the effectiveness of the interventions. • There was no comparative analysis of health and functional status from the previous year. • There was no analysis of findings that was based on the data reported and compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. • Specific health risk ratings established by the PST were not identified and interventions, primarily the PNMP, were not specifically linked to these ratings. Approximately 49 out of 61 (80%) assessments reviewed described individuals with significant movement disorders and limitations in self-care and/or functional skills. The following information was also noted based on the documents submitted and these individuals would likely require supports and interventions by OT and/or PT beyond only a PNMP. There were: • 216 (55%) individuals identified with PNM needs per the list submitted. • 135 (34%) individuals identified as non-ambulatory or requiring assistance for ambulation.	

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		• 78 (20%) individuals who used a wheelchair as a primary means of mobility. • 21 (5%) individuals who used assistive equipment for ambulation. • 35 (9%) individuals who used transport wheelchairs as needed. • 107 (27%) individuals with upper or lower extremity orthotics and/or braces. • 41 (10%) individuals sustained an injury resulting in a fracture. Ten of these individuals were either non-ambulatory or required assisted ambulation to some degree. • Over 80 (20%) individuals had experienced falls in the last three months. There were 24 individuals who experienced a slip, trip or fall resulting in a serious injury. Individual #175 sustained a serious injury "during bathing." Individual #120 fell in the bathroom and sustained a fracture of the right distal tibia/fibula. Individual #72 sustained a fracture of the humerus secondary to lifting or transfer. • 42 (11%) individuals had one or more incidences of pressure ulcers/skin breakdown in the last year. • 30 individuals were listed with contractures. • 26 individuals were listed with chronic pain • 98 individuals were diagnosed with osteoporosis. Another 24 were diagnosed with osteopenia. Both a new PSP process and Health Risk Assessment process were in development and would likely further impact the OT/PT assessments over the next year. **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 and specific range of motion measurements were provided, though a comparison of status compared to the previous assessment was inconsistently reported. Movement skills were addressed, but focused more on transfers, ambulation, and bed mobility, rather than fine motor skills. Specific information in this area would offer more useful information to the clinicians and other team members for training or active treatment purposes. For example, in the case of Individual #395 the clinician reported only that his hands were "unremarkable" in conformation, except for flat arches, but there was no description of how he used them other than to put his left	

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		hand behind his head. As described above, there was most often several generic statements as to hand use, but no functional examples were reported. There was no fine motor section documented in approximately 30% of the assessments for individuals reviewed (Individual #328, Individual #178, Individual #304, Individual #528, Individual #120, Individual #188 and Individual #500, among others). In general, the OT/PT assessment format was comprehensive, but the content was not consistently so. Some examples included: • Individual #500: The update did not address each of the headings listed in the format submitted and generally noted in other updates. The Activities of Daily Living section stated only that he should sit during bathing. No other discussion of his abilities in other areas of self-care or dressing was addressed. Fine motor skills were not described • Individual #365: It was reported that his sensorimotor function remained unchanged from the previous assessment dated 2/22/10. Unless the baseline assessments are maintained in the individual records, this type of statement is useless to clinicians and direct support staff. • Individual #322's sitting and standing balance were described as poor, yet there was no functional description of what that involved or why the clinicians had made that judgment. Individual #53 was described with fair sitting and standing balance. Individual #132's sitting and standing balance was described as good. Individual #497's sitting and standing balance was not described at all. The scale used to rate balance in sitting and standing, well known to therapy clinicians, would not be useful to others who may need to understand these skills. More functional descriptions would also allow the therapists to conduct an analysis of these skills in order to ascertain whether interventions would be indicated. • Individual #304: Per her comprehensive evaluation dated 8/30/10, it was reported that she was seen for acute care treatment from 1/29/10 to 8/13/10 following a stroke. There was no documentation of how often the treatment was provided, what the treatment involved, and how she responded to over eight months of OT. No functional goals were listed. Further, it was stated that she was provided bilateral hand splints, but there was no documentation as to when the splints were provided, what kind of splints they were, what the wearing schedule was, or her hand range of motion prior to the application of the splints or at the time of this assessment. In the PT consults section of the report, it was documented that Individual #304 was seen five days a week by PT, but what that involved was not described. It was also reported that she had participated in the walking clinic until 1/29/10 when she was placed in the transfer clinic and the walking clinic and a soft shell helmet were discontinued. There were no functional goals stated. There was no rationale for any PT intervention. There was no clinical analysis of findings that was based on the data reported and	

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		compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. OT and PT treatment were not recommended, but there was no rationale for that determination. • Individual #257: Her evaluation update, dated 9/17/09, (no more current assessment was present in her individual record), indicated that she had regressed with regard to transfers and ambulation as she could only walk with PT while previously she had walked in her home with contact guard assistance. There was no analysis of why she had regressed anywhere in the assessment. The recommendations indicated that she had participated in a walking program only one time a week since 7/29/09. It was not clear when the regression was noted and how walking with PT one time a week would adequately address this regression. There were no functional goals stated. There was no report as to how effective this intervention was. • Individual #328: He was described with severe flexion contractures of both wrists and moderate to severe flexion contractures of both elbows. Specific range of motion measurements were not documented. It was further stated that his upper extremity deficits were "long standing" and did not respond to therapeutic intervention during the evaluation, yet he had received OT intervention to address his wrist contractures and for splinting. There was no statement as to the rationale or efficacy of this treatment. OT was not recommended per this Comprehensive Evaluation dated 8/19/10 **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.** Comprehensive assessments were not provided upon a change in status but rather OT or PT consults were noted for some of the individuals reviewed. A Consultation Summary Report was completed with findings and recommendations. The date of referral was not consistently included in the consult reports, but for those for whom this was indicated, it appeared that the response had been in a timely manner, with a few exceptions of five to seven days (Individual #151 and Individual #72), as well as the following examples: • Individual #38: A new custom seat back for his wheelchair was requested on 9/1/10. It was reported that he did not receive it until 12/8/10. A modification was necessary and the seat back was returned on 1/5/11. He was using the old back until the new one was complete. The summary was dated 2/1/11, five months after this request. There was no evidence that the new back had been provided at the time of this onsite review. While it was not uncommon for equipment to take more than 30 days for delivery, especially in the case of custom	

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		components fabricated off-site, this seat back took three months. Tracking the timeframes for the delivery of equipment will be essential to problem resolution related to specific vendors used by the facility and the ATP. • Individual #518: A physician referral was made on 9/9/10 related to "relieve traumatic injury to finger tips and palm." There was no evidence of a response to this request until 9/23/10, two weeks later. The time frame for a referral of this nature was not acceptable due to the high risk of infection and further injury. At that time it was stated that a doctor's order was necessary for OT five times a week for 30 days to improve skin integrity for splint wear. There was no assessment other than to state that there was "a large amount of power" noted bilaterally. Two wash clothes had been rolled up in her hands to protect them. By report, splints were applied for 15 minutes and were tolerated with no problems. There was no description of the type of splint applied. A physician's order was made on 9/23/10 regarding assessment of bilateral hand contractures for Individual #518. A Consultation Summary Report dated 9/23/10 by Doris Ricketts, OTR, MBA, did not reflect an assessment, but rather a recommendation that she receive direct therapy to increase finger extension for splint wear. At that time, Individual #518 wore mittens on both hands to prevent her from pulling at her PEG tube. By report, she had been observed digging her fingers into her palms and leaving nail marks and she had lost active range of motion of her fingers. The OTR stated that Individual #518 should continue to wear the mittens until she could be fitted for splints. There was no assessment of the baseline range of motion for her hands and no description of the contractures identified as the reason for the referral. There were no measurable goals identified for the recommended treatment. She was seen for OT services by a COTA from 9/24/10 to 11/19/10 with weekly progress reports. These were filed in the integrated progress note section of the personal record. Though the notes stated that the COTA was supervised by the OTR, there was no evidence of a treatment plan or measurable goals. The COTA documented the course of treatment and progress in a quantifiable way with the exception of range of motion measurements. A discharge summary was written by the OTR stating that Individual #518 had "met her goals." It was not clear how that was determined because no goals had been established at the time of assessment or initiation of treatment. As of 3/1/11, Individual #518 continued to wear bilateral hand mittens and was placed at an enhanced level of supervision despite having received splints. There was evidence of both of these restrictions as far back as 3/23/10 per the documentation submitted. While these restrictions were described as medical restraints, their long term use suggested that there was an unresolved behavior issue. There was no PSPA to address the initiation, termination or progress related to direct OT services and splint wear. There was no evidence of PST discussion to determine if the mittens could be discontinued once she was fitted	

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		with splints as suggested by the OT on 9/23/10. • In the case of Individual #188, she was seen by OT on 10/11 and 11/4/10 per a doctor's order (no date noted) for evaluation of her positioning post-hospitalization for aspiration and urinary tract infection. A PEG tube had been placed. It was typical that the therapists responded to referral or requests rather than an established practice for automatic review and assessment as indicated after hospitalizations for PNM-related concerns and other significant changes in health status. In the case of Individual #188, she should have received a full comprehensive assessment by OT and PT, rather than a consult by the OT only. Her most current OT/PT assessment was dated 7/12/10. • A Consultation Summary Report for Individual #369 dated 4/30/10 was a response to a request (4/28/10) as a result of "redness to buttock." The OT completed pressure mapping with her current cushion. Per the OT, the pressure mapping revealed no concerns and it was concluded that the cushion was meeting her needs and "no recommendations are needed." There was no evidence that this clinician attempted to assist the team in determining what may have caused the redness in an attempt to resolve the issue and prevent further skin integrity issues. Per the list of "Pressure Wounds" dated 2/15/11, Individual #369 had a documented Stage II pressure ulcer with onset on 4/27/10 on her coccyx. There may have been other reasons related to handling or positioning that contributed to this issue. There was no evidence that the OT conducted a thorough review of Individual #369's status in collaboration with nursing and PT to determine if there were additional problems that required attention. **Standard: Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment.** The assessments reviewed did not recommend further specialized evaluations for wheelchair seating or for other issues. Referrals to medical or to the orthotist were noted for some, however. Wheelchairs were generally reviewed on a quarterly basis for maintenance. There was no evidence that there was more frequent review of the appropriateness of seating equipment and wheelchairs. The annual assessments typically described the seating system components for individuals, but did not consistently address whether the system was appropriate as to fit, function, and condition. Some examples: • Individual #188: It was reported in her baseline assessment dated 7/2/10 that she was using an E&J wheelchair with a sling seat and back with a "1" cushion with red handles for mobility only. There was no statement as to how this wheelchair did or did not meet her needs. It was reported that she used the wheelchair off the unit. She required contact guard assistance from one staff with a gait belt. She was evaluated at that time for a Solara tilt-in-space	

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		wheelchair due to a decrease in dynamic standing falls and ambulation. While it was reported that she had fair sitting balance and poor standing balance there was no justification provided as to why she would require a new wheelchair, particularly one with a tilt-in-space function. There may be sufficient reason for this, but the evaluation did not present the data with appropriate analysis to support this clinical decision. • Individual #291: In the baseline assessment dated 6/11/10, there was no description of her current wheelchair, but only that it did not met her postural needs. Without justification it was determined that she now needed a Solara tilt-in-space wheelchair. It was reported that she continued to perform stand pivot transfers, walked with contact guard assistance from one staff, and was independent in bed mobility. • Individual #303: Her baseline assessment dated 2/11/11 stated that she used a Solara tilt-in-space wheelchair for mobility off her home. There was no statement as to whether this seating system met her needs with regard to fit, function, or condition. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** The assessment format only offered a list of diagnoses. In some cases, there was a reference to a health issue elsewhere in the report, but there was no specific review of health events, special consults, or diagnostics conducted during the previous year. References to the PST risk assessment and ratings were not noted, and in some cases the issues were not addressed adequately in the assessments and supports. Some examples: • Individual #494: She was identified at high risk for injury, per the HST documentation submitted. While the baseline assessment dated 8/7/10 listed seven injuries related to falls, there was no mention of this as a high risk issue for her. The clinicians did not use this information in the formulation of the PNMP or for interventions to address this concern. In addition, Individual #494 had experienced a choking incident in May 2010 and though this was reported in the assessment, she was listed at low risk for nutritional management concerns and choking. This despite it was reported that she ate too fast and took too large a bite. There was no reference to choking risk on her PNMPs as submitted for the last 12 months. The only stated focus was to "promote independence using assistive equipment." • Individual #38: He was identified at high risk for weight and respiratory concerns and at medium risk for aspiration per the HST documentation submitted. Per the assessment dated 11/2/10, there was a more in depth	

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		assessment of his respiratory status with oxygen saturation levels evaluated at various degrees of tilt. The NMT had established his risk for aspiration as high and was inconsistent with the HST designation. Despite these concerns, the stated focus of his PNMP was to "prevent and maintain joint contractures and deformities, facilitate skill acquisition, and promote and maintain comfort and good health." There was no reference to the issues related to his weight, respiratory and aspiration risks in this assessment or in the PNMPs submitted for the last 12 months. The stated focus was to "promote good skeletal alignment" and to "promote good nutritional status through enteral tube feedings from a licensed Nurse." • Individual #557: Per the HST documentation submitted, she was at high risk for seizures. The only reference in the OT/PT evaluation dated 10/15/10 was that she had a diagnosis of epilepsy that was well controlled. She was reported to have had several falls during the previous year, but it was not stated whether these were seizure related. She was provided a helmet "due to injuries from falls." There was no discussion of any possible correlation between her seizure activity and her falls. She was reported by staff to have decreased ambulation and refusals. She previously walked to the dining room and only walked within her home at the time of the assessment. Recommendations included walking clinic two times a week and walking with staff four times daily using a gait belt, rolling walker, and helmet. There was no reference to seizure risks or risks of injury due to falls in her PNMP updated 2/17/11. The stated focus was to "maintain skin integrity and independent mobility skills." • Individual #151: Per the HST documentation submitted, he was at high risk for weight, osteoporosis, and aspiration. In his OT/PT evaluation dated 10/20/10, there was no discussion of these health risk issues to justify recommendations and supports. The physical management focus was to "prevent skin breakdown and deformities, facilitate skill acquisition, promote or maintain comfort and good health." There was reference to the NMT concerns for chronic aspiration and it was reported that he had PEG tube placement on 2/12/10. There had been no comprehensive assessment at that time, however. It was stated that his dining plan had been reviewed on 9/20/10 and he needed new pictures of him eating in his wheelchair, but as of this assessment, that had not apparently been provided. The plan updated on 9/1/10 merely referred staff to his dining plan despite the fact that he was enterally nourished at that time. The plan updated on 9/28/10 referenced the dining plan, but also added that he should sit in his wheelchair for all feedings except the 9 pm in the recliner. He was to remain upright for one hour. There was no statement that he was enterally nourished or at risk for aspiration. The focus was to promote skin integrity with independent positioning and assisted mobility. The clinicians stated that this assessment "represents	

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		regression." No OT/PT treatment was recommended. • Individual #197: Per the HST documentation submitted, he was at high risk for osteoporosis. There was no reference to this concern in his OT/PT evaluation dated 7/29/10. There was no reference to this in his PNMP updated on 2/16/10. Efforts to identify the rationale for some supports were noted, though these were generally scattered throughout the report and there was no comprehensive analysis of findings that included both health and medical concerns with a description of functional skill abilities and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs. There was a new PSP and risk assessment process that should result in changes in the way this is addressed in the clinical evaluations completed by OT and PT. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** The OT and PT clinicians conducted their annual assessments together, though issue-specific consults were generally conducted by only one of the therapists. They appeared to work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and other supports and services as indicated.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall 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	**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.** Plans were generally limited to the PNMP that was reviewed at the time of the annual PSP and was updated as needed due to a change in status. In the sample of 24 individuals for whom individual records were requested, 100% of the plans were current within the last 12 months. There were a total of 221 plans submitted. Plans for Individual #340, Individual #462, and Individual #276 were not dated. Plans for Individual #540 and Individual #278 had an updated date of 2/17/11 due to a "book change," but the implementation dates were 5/14/09 and 9/17/09, respectively. It was not clear if they had not been reviewed since that time. There was evidence that the majority of the plans were reviewed and updated at the time of the annual staffing and at other times related to program changes with the new PSP date documented on the plan. Changes were identified by an asterisk to alert staff to a change from the previous version. Other interventions were not documented in a specific plan and were not generally included as an aspect of the PSP. PSPAs were held routinely by the PSTs though per the documentation submitted, licensed OT/PT clinicians did not regularly attend these meetings even when the discussion was PNM-related. In some of these cases, the PNMP coordinator attended. This level of staff was not able to contribute clinical information to	Noncompliance

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	and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	the team in order to develop appropriate supports to address PNM needs. It was reported that therapists attempted to attend PST meetings for priority individuals at high risk. They reported that in some cases, only one discipline (OT, PT, or SLP) attended as a representative for the department. Information for PSPAs was provided via email and Consultation Summary Reports. Some examples included: • A PSPA for Individual #503 was held on11/10/10 to discuss a nursing care plan due to open area on his buttocks. Only the PNMP coordinator was present at this meeting. It was not possible to determine if OT/PT had provided assessment or supports to address this concern as the integrated progress notes from 9/12/10 to 11/16/10 were omitted from the document request for Individual #503. There were no progress notes written by OT or PT from 11/15/10 through 3/22/11 other than to document that a PNMP clinic had been conducted. **Standard: Within 30 days of development of the plan, it was implemented.** As there were very limited interventions provided beyond the PNMPs, this element was not in compliance. Generally, however, when an action was identified as necessary to address a more acute issue, these actions were taken well within the 30 day period, often on the day of or day after a referral or request with some exceptions described above. These did not consistently involve a PSP addendum. In some cases, PSPAs were held related to an OT/PT issue, but the therapist did not attend, but rather the PNMPCs attended some of these meetings. Documentation by the clinicians was consistent in most cases and documentation was daily for each session or weekly. Monthly review to summarize progress across the month or quarter was inconsistent, however in some cases, there was no documented rationale for the need for therapy other than a doctor's order (Individual #132). Despite an order for therapy, the clinician had a responsibility to establish a clear justification for therapy and a specific plan of treatment with measurable and functional goals and outcomes. In the case of Individual #395, he had received ongoing PT services to address range of motion for his hips and knees per a baseline evaluation dated 6/3/10. The assessment documented regression despite this intervention. Recommendations were to continue PT with nursing application of knee braces three times daily. An Acute Care Assessment was completed on 9/20/10 with a note documented nearly a month later on 10/25/10 to extend the order for PT four times a week for an additional 30 days. This assessment reported that there had been no change, but identified specific measurable, though not functional, goals. Progress notes from 9/30/10 through 1/27/11 indicated that range of motion was provided and that Individual #395 was able to sit on the edge of the bed with maximum assistance of one person. There had been no further assessment of his progress as of 1/27/11, no specific measurable goals and as such no clinical justification for continued treatment.	

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		While documentation was included in the integrated progress notes section, they were not an aspect of documentation for quarterly PSP reviews. **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 analysis of findings in the assessment reports to provide a rationale for the PNMPs developed for individuals. There was no rationale identified in the plans themselves other than a couple of statements of focus. As described above, these statements were not consistent with the risks identified by the PST. Most of the PSPs submitted were of the old format that only listed the recommendations from the OT/PT assessment rather than an actual review of the PNMP. The new format and process for the development of the PSP had potential for improved integration of the PNMP, though this was not evident as yet in the new format PSPs reviewed (Individual #143, Individual #132, Individual #427, Individual #321, Individual #175 and Individual #441). Implementation of the PNMP was listed as a service objective to address the stated focus. Other service objectives included OT/PT assessments, PT interventions and staff inservice. There were no training objectives designed by OT/PT with implementation by paraprofessional staff to address skill acquisition in any of the PSPs reviewed. In the case that direct therapy was provided (Individual #132), there was no measurable, functional goal listed as an outcome of direct intervention. Individual #132 had received an OT/PT baseline evaluation on 12/20/10 upon his admission to MSSLC. This assessment was not submitted for review. A Comprehensive Evaluation, dated 1/3/11, was completed and it was reported that he had been referred by medical on 12/28/10 for "strengthening exercises for core muscles, cervical spine and shoulder joints." He was reported to have been in a motor vehicle accident as a child and had been in pain since that time. All findings reported were within normal limits and there was no description of his pain as to where, when, severity, or frequency. There was no report as to other methods of pain management, such as medication. With absolutely no rationale, PT was recommended three times a week for 30 days. Treatment notes were written on 1/13/11 (he did not attend on that date), 1/20/11 (seen one time that week), and on 1/27/11 (seen two times that week) by the PTA. It was reported that he did not have any complaints of pain and performed neck exercises, trunk exercises, and shoulder strengthening exercises. Recommendations were that he should continue PT services three times a week for 30 days. There was no baseline or measurable goal established for this intervention.	

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		Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression. Other than the limited evidence of direct intervention discussed above, the primary support provided was via the PNMPs. PNMPs addressed areas related to positioning, transfers, range of motion, and mobility, but interventions were limited related to promoting independence and skill acquisition. PT intervention was generally designed to address gait, ambulation, and transfers and range of motion. The OT intervention was designed to promote range of motion or to provide splints. The few interventions in place were generally well documented, however, the scope of service was limited to a handful of individuals only, and none of these had established measurable and functional goals. Justification for continued therapy or discharge was not well justified as a result. Programs and interventions for other skill acquisition were not identified as a need and, as such, were not provided. PNMPs included staff instructions or precautions in the areas of movement, mobility, transfers, positioning, bathing, skin care, medication administration, oral hygiene mealtime instructions, behavior concerns and communication. The instructions for bathing, medication, and oral hygiene did not consistently address position, alignment, and support for those with special needs. Mealtime instructions addressed position or NPO status, but then only made a reference to the Dining Plan with no specific mealtime instructions provided. There was a very brief communication section. A list of assistive equipment was consistently provided in the plan. Hearing and vision status was identified for each individual. The focus of the PNMP was listed, but did not clearly relate to the health risk system in place at the facility. There was a new risk assessment system implemented as of 1/1/11 and this should drive the need to revise the plans to accurately reflect the identified risks and the necessary supports for each individual. **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 assessments inconsistently provided a brief rationale for the equipment recommended for use. Pictures were provided for staff reference as an aspect of separate instructional plans as to details for alignment and support for bed, wheelchair seating, and use of braces or orthotics. These were not consistently present in the individual books and in some cases were not current within the last 12 months. For example: • Individual #175: The plans for her edema boots, head of bed guidelines, and back positioning were dated 12/31/09.	

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		• Individual #79: Plans for recliner use and back positioning plans were dated 11/8/09. The plan for wheelchair seating was undated. • Individual #328: Plans for positioning guidelines (back and sidelying) were dated 10/17/09. The plans for sidelying and his upper extremity splints were undated. • Individual #567: Plans for compression sock guidelines were dated 11/28/09. The plan for guidelines for locking and unlocking his walker was undated. • Individual #38: Plans for positioning guidelines for back and compression sock guidelines were dated 11/16/09 and 11/15/09, respectively. • Individual #321: Plans for compression sock guidelines and edema boots were dated 1/18/10. The plan for wheelchair seating was undated. • Other plans submitted for other individuals were not dated at all, so it was not possible for staff to discern if they were current and appropriate (Individual #257, Individual #151, Individual #304, Individual #477, Individual #188, Individual #518, Individual #38, Individual #542, Individual #143, Individual #503, Individual #369, Individual #432, Individual #72, Individual #16, Individual #469, Individual #293 and Individual #435). Pictures noted, however, were large and very clear with useful highlights for staff as cues or reminders of the critical components of the prescribed supports. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** There were few intervention plans, though these were generally documented via a Consultation Summary Report or a Physician Ordered Treatment Progress Record. Measurable goals were not established with performance criteria clearly outlined. Documentation was consistent and in some cases described progress, but without a clear baseline and/or specific measurable goal, continued intervention was not well justified. As a result, the decision to continue therapy or discharge was not supported. As described above, there was no rationale for the initiation or continuation of direct PT services for Individual #132. **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.** In the case that an individual received direct therapy, progress notes were written for each session and were generally included in the integrated progress note section. In the records reviewed, however, there was no documentary evidence of routine review by the	

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		OT or PT for interventions conducted routinely by assistants. Reviews of the PNMP were conducted on an as needed basis upon referral or based on the findings of monitoring. Monitoring by the PNMPCs was intended to ensure routine monitoring of the PNMPs. Individuals considered to be at high risk were to be monitored two times a week, however, each PNMP Coordinator had his or her own system of keeping up with that and if not completed, it was deferred to the subsequent week. There was no system to track the actual frequency of monitoring. Also, the PNMPC work schedule was generally 8:00 am to 5:00 pm with a flexed schedule to come in early one morning a week. They reported that sometimes they stayed later (6:00 pm or 6:30 pm) to observe a meal or positioning and bathing. This was on the honor system and monitoring was very limited in the morning before 8:00 am and on the second shift in the evening during the meal or afterward. One PNMP Coordinator reported that she requested that staff bathe individuals at certain times so she could observe the process. Others asked the staff to rotate individuals or let them know the day before that they would be conducting monitoring of a specific individual.	
P3	Commencing within six months of the Effective Date hereof and with 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.	**Standard: Staff implements recommendations identified by OT/PT.** Though equipment generally was available and improvements since the last review were noted, implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standards of care. 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 #291 was transferred from a recliner to her wheelchair by professional staff. While the transfer was competently done, the clinicians did not adjust her pelvis after she was seated before she applied her own seatbelt. Eventually the COTA ensured that the appropriate adjustments were made. • Individual #547 was seated in a transport wheelchair (red handles) with a sling seat that was way too small for him. • Individual #140 was observed in his wheelchair in a posterior tilt. It could not be determined if the seat depth was too short or if he was not positioned in it properly. The seat did not provide adequate support throughout the length of his upper leg or thigh. His right leg was elevated though the reason for this was not identified in his PNMP. When the staff was asked, they reported that he had problems with swelling and wore TED hose. It was noted by the monitoring team that he was not wearing the hose that afternoon. When asked about who was responsible for this, the staff replied "whoever works with him in the morning." • Individual #469 was observed in his wheelchair without footrests. He was	Noncompliance

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		observed to propel the chair with his hands and was reported to use his feet as well. The seat appeared to be too high from the floor to adequately support this. He was wearing socks with no shoes. This was inconsistent with generally accepted safety practices. If this was considered to be acceptable by the therapists, there should be something to indicate this on his PNMP. • Individual #79 was observed in his wheelchair during day program. His head was well below his head rest and his knees extended beyond the edge of the seat by five to six inches. The classroom instructor was prompted to reposition him with the QA staff present. The instructor was observed to lift up under his knees only and was not successful in placing his pelvis well back into the seat and did not check that it was level and not rotated. This had to be repeated again and again she was unsuccessful. This process was repeated a third time with the QA staff taking the lower body position. The instructor had difficulty lifting up at the trunk and required numerous prompts and cues. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. Transfers observed were generally completed appropriately. It was reported that CTD staff completed the training for lifting and transfers in annual re-training for staff. Per the schedule submitted for NEO, an SLP was scheduled to conduct training in Physical Management. It was of concern that these staff would be competent to present content, demonstrate skills, and answer questions as required during the training. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** Transfers and lifting training offered in New Employee Orientation (NEO) was competency-based. As reported at the time of this onsite review, however, this training was conducted by a PT technician in NEO training and by staff development personnel for annual re-training. There was no evidence that the trainers had been competency trained to conduct this training with routine review by licensed clinicians for consistency of content, demonstration, instruction, or competency-testing strategies. Other PNM training for new employees was conducted by therapy staff, though as stated above, an SLP was scheduled to conduct Physical Management training on 2/10/11, per the schedule submitted. As of 2/16/11, the PNMPCs followed new employees after completion of training for two weeks. If staff did not demonstrate competency using the monitoring questionnaire, they were required to repeat NEO training related to PNM. If after 30 days, competency was still not established, the staff person was to be transferred to a different living area with a decreased level of care. This system had great promise as a follow-up to NEO, however, there was no documentation that the PNMPCs had been competency-trained to demonstrate the same skills required from direct support staff, to	

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		conduct monitoring or training and competency check-offs for others. This would be an essential aspect of this system to ensure effectiveness. Individual-specific training was reported to be competency-based. Licensed therapy staff provided inservice to available direct support staff on first and second shifts. Home managers or supervisors were then responsible to provide training for additional staff and the 10 pm to 6 am shift and floater staff from other areas to the home. The PNMPCs also provided staff training. Training documentation reviewed consisted of an Employee Continuing Education or Miscellaneous Training Roster that included the program title, dates of training, educational goals/objectives, and a summary of program content. The instructor was listed. The signature sheet was attached. Some of the signature sheets submitted had a designation of "T", "D," and "V" for test, demonstration, or verbal evidence of competence of the goals/objectives designated in the training, however, there was no checklist of actual competencies listed. As described above, there was no mechanism to ensure that only staff who were competency-trained were assigned to work with individuals at highest risk. There was also no system to ensure that home managers conducted training in the manner expected to ensure actual competency of skill performance by staff. A request for competency-based training sessions addressing foundational PNM skills for the last six months was requested. Documentation for only three sessions conducted by two OTRs and a COTA were submitted: (1) 30 minute training on bed positioning and pressure relief on for 18 staff on 12/10/10 for Individual #72 (this documentation was duplicated three times); (2) Off Campus Adaptive Eating Equipment for 25 staff on 12/9/10 (length of training was not specified); and (3) Transfer Training for 10 PNMPCs on 8/16/10. The transfer training description was related to the "basics of choking, risks for choking, and monitoring individuals for techniques and equipment as described in the dining plan" and, as such, was not consistent with the title. The length of the training was not specified and there was no designation of the specific competencies demonstrated by the participants. The attached signature sheet did not designate "T", "D," or V." The training on 12/10/10 for bed positioning for Individual #72 described that staff were instructed on the proper use of denim sheets for all positioning/repositioning when the individual was on bed rest in supine positioning per doctor's order. There was no list of steps or strategies required to perform this skill correctly. It appeared that the staff signing that they had participated in the training circled whether they were competent based on demonstration of a specific skill or that they verbally acknowledged an understanding of the information. For example, "V' (verbal) was circled for nine staff. Both "D" (demonstration) and "V" were circled for six staff, and nothing was circled for three other staff. Individual #72 had experienced a fracture of his humerus on 12/2/10 that was suspected to have occurred during a transfer or repositioning. As such, he was at significant risk and it was critical that staff could accurately perform skills related to this	

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		individual. The documentation of the training related to off campus adaptive eating equipment clearly described the information and expectations of staff, but there was no evidence as to how the 25 participants demonstrated competence or understanding of the information presented. Their signatures merely confirmed their attendance. Additional training documentation was submitted with the records for some of the 24 individuals for whom individual records were requested. This included additional training sessions for staff again related to Individual #72 on 12/23/10 by a COTA. Again, there was no designation of the specific expectations for competency or how it was established for the participants. Documentation for 22 other training sessions conducted was submitted. Half of these used the documentation format described above, and 16 used a different training roster form and signature sheet form. These required the trainer to specify the competency tools used (written test attached, demonstration and type or verbal quiz with questions to be specified) as well as pass/fail and need for retraining designations on the signature sheet. Five of the forms did not indicate whether the participants passed, failed, or required retraining. For another five forms, 100% of the participants were listed with a passing grade. For the other six trainings, only 43% of the participants were listed with a passing grade. There was no designation for the other participants and none were identified as requiring retraining. Each of these used a verbal quiz only to establish competency. None of these required return demonstration of skills required for implementation of the plan. **Standard: Staff verbalizes rationale for interventions.** Staff were not consistently able to discuss the rationale behind recommended interventions. The rationale for interventions and supports was also not included in the PNMP related to specific strategies. This is an important aspect of staff training as well as monitoring and coaching. The focus of the PNMP highlighted the overall risk issue for the individual as a rationale for the plan, but detail as to why a specific strategy was used was not consistently indicated on the PNMP. As described above, however, there were significant risk issues for individuals that were not listed in the PNMP.	
P4	Commencing within six months of 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	**Standard: System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.** The form used for monitoring had been revised and was titled "Comprehensive Monitoring Form" and was described in section O above. This system monitored for availability and condition of adaptive equipment and assistive technology but did not address fit or function as it related to a specific individual. Additional maintenance requests were to be conducted on a quarterly basis. Per the database submitted, these	Noncompliance

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	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.	were documented from three- to six-month intervals though work orders were noted throughout the year in response to a request or reported concern. A COTA reported to monitor wheelchairs on a monthly basis, but there was no consistent method to document this and none was submitted. Occasionally, a notation in the integrated progress note section of the individual record was noted related to a wheelchair or splint, but this was not common, consistent, or routine. The therapy clinicians did not conduct routine reviews, but rather responded to problems identified via monitoring or referrals. To date, there was no analysis of the monitoring completed to date for validity or consistency or to examine trends in and across homes to drive a focus for staff training. Assessments were conducted as needed for new seating systems or for modifications to existing systems. It did not appear, however, that specific wheelchair assessment reports were produced by the clinicians or that mat evaluations were formally documented in any manner. During a mat evaluation observed by the monitoring team, there was no documentation noted by the therapy clinicians. When the monitoring team asked about this, one therapist left to obtain a form. Previously, a formal mat assessment was often not conducted or documented. On this date, one of the new contract OTRs was present and led the team through a more thorough and appropriate evaluation. The therapists continued to work with the ATP/vendor at this time and he completed a consultation form for each evaluation or re-assessment. It was not acceptable that only the vendor completed a written report, but rather the clinicians involved should also produce a comprehensive report of the mat evaluation as well. This documentation should provide the data obtained from the assessment, a clear outline of the individual's functional needs and goals for the system, and the rationale for the selection of specific products that were determined to match the identified needs/goals. Further, any reviews of wheelchairs and seating as well as fittings and delivery notes should be well documented by the therapists. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** Since the majority of monitoring was conducted by PNMPCs, it was primarily limited to availability and condition of equipment as well as staff implementation, rather than efficacy of the interventions in the PNMPs. The frequency of monitoring was not driven by level of risk, though this will continue to be modified as the new risk assessment process is implemented. Monitoring sheets for the last three months were submitted for review. There were numerous forms submitted, completed by the PNMPCs. The forms generally identified where observation took place (the individual's home). The date was consistently reported, but the time of the observation was not. The activity observed was checked, but	

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		there was no way to identify the name of the staff working with the individual. Completed monitoring forms (245) for the last three months were submitted for 24/24 individuals included in the sample for whom individual records were requested. There were 112/245 (46%) of completed forms with a "no" response indicating noncompliance with implementation of the PNMP. There were a number of inconsistencies noted and indicated that the PNMPCs were insufficiently trained to monitor individuals appropriately or provide adequate training to other staff. Some issues noted included the following: • Despite a notation on the form stating that a "NO" response to a question required a comment and notification of Habilitation Therapy, there was not a comment consistently documented to describe the problem or concern and there was documentation of notification of any other staff on only 4/112 (3.5%) forms for Individual #503 (1/6/10 and 12/27/10), Individual #72 (12/18/10), and Individual #328 (2/9/10). • On 1/5/11, The monitor for Individual #143 reported a "no" for five indicators on the form including: (1) Is the activity safe?; (4) Does the individual's position match the recommendations on the PNMP?; (5) Is an upright head position maintained?; Are techniques implemented according to the PNMP?; and (8) Was the activity completed at a safe rate? Only the first had a comment (Individual #143 was lying flat in her bed) and no one was notified of the problems observed. Similar issues were noted related to positioning for Individual #503 and Individual #518. Comments were documented in those cases, but no one was notified of the concerns observed by the monitor. • Special concerns (monitors were to circle concerns when observed) , such as food or fluid loss, coughing or clearing, wet voice quality, drooling, poor dining posture, head tilted back or forward, or meal refusals were not documented even one time for any individual across a three month period. • In a number of cases, the question was marked "partial," which was not an option per the existing format. For example, in the case of the Individual #503, the monitor commented that "feeding technique not good," "fed from tray" and "too much on spoon," yet marked partial for "Is the equipment present, used correctly and in good condition?" as well as "Is the atmosphere pleasant and safe?" **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 were no policies or guidelines to address the monitoring process. Procedures were communicated to staff via inservice training. There was no formal method to validate PNMPCs to ensure consistency. There was no formal analysis of findings to identify and	

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		track trends or to drive staff training. **Standard: On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.** Staff were monitored as an aspect of the individual specific monitoring conducted by PNMPCs. There was no tracking however to determine if this covered all staff who were responsible for implementation of PNMPs. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** As described above, however, these were not well integrated with the PSP process. Documentation was maintained in the integrated progress notes, but the status of these plans and the individual's progress were not included in the PSP process. There was no evidence that the PTs or OTRs documented a review or summary of monthly progress for interventions conducted by assistants and there were no SPOs designed for implementation by direct support staff or classroom instructors with monitoring and documented review of implementation and progress by the licensed clinicians. **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 .** There was no system to assure that those who were most at risk were assisted by competent and well-trained direct support staff only. Specific examples were described in section O above. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** There was no standardized method to document action on findings from the PNMP monitoring through to problem resolution. The new monitoring form only provided a blank for the monitor to document the names of individual's to whom they reported their findings. This was rarely identified there was no mechanism to track findings, problems or resolution. **Standard: Data collection method is validated by the program's author(s).** Only direct treatment plans were implemented and the data was reported in a daily or	

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		weekly progress notes. There were no monthly summaries intended to summarize the individual's progress. There were no measurable, functional goals. As more programs are developed for implementation by direct support staff, a system of data collection sheets with review and analysis by the therapy clinicians will be necessary to track progress on a routine basis. Validation of the accuracy of data collection should be a critical aspect of this review. This should be well-integrated into the PSP process. Further assessment in this area will be needed during future onsite reviews by the monitoring team.	

Recommendations:

1. It is critical that the new therapy clinicians participate in continuing education and clinical instruction available through the State in order to become familiar with process of PNM supports and services. Also it is critical that they receive an extensive overview of the expectations of the Settlement Agreement.

2. Integrate new risk assessment process into the OT/PT assessment, in the development of intervention/support plans, as well as to guide monitoring and staff training needs. Risk indicators should be considered in a more integrated manner throughout the report. A comparison of health and functional status from the previous year should be documented and reference to the baseline should be made in the update. The analysis of findings should cross all systems or clinical areas and should formulate the foundation or rationale for why specific aspects of the PNMP as well as other supports, service and interventions were indicated. These should then be listed as recommendations.

3. Address skill acquisition in the OT/PT assessment. More discreet task analysis and observation generally will yield greater specificity, laying a better foundation for potentials for learning and the design of implementation programs and plans. Provide functional descriptions of skills rather than general statements such as "hand skills for reach and grasp were intact." Specific examples will be more useful to therapists and other team members.

4. 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. All PNM-related risk issues must be considered when assigning needed frequency of PNMP and mealtime monitoring.

5. Integrate direct and indirect supports into the PSP through the development of SPOs that included measurable goals with performance criteria. Ensure that there is a clear measure of progress related to the goals and that these and other critical clinical measures as well as functional health status indicators to justify initiation, continuation and/or termination of interventions.

6. 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. These same steps could be applied to training techniques and skills as well.

7. More oversight and directions were indicated for the PNMPCS in order to ensure that there is consistency in the schedule and frequency of

monitoring. This should be reviewed for compliance on a routine basis. Also monitors should not request that staff adjust their schedule to accommodate them. The monitors' schedules may need to be changed in order to ensure a better sample across all shifts and activities when PNM practices are used. PNM monitoring is not a task that can be completed in a competent and thorough manner only from 8:00 am to 5:00 pm.

8. Review of assistive equipment during assessments and routine monitoring should not merely address condition and implementation but also fit and function.

9. PNMPs should provide justification for supports outlined as well as a clear link to the health risk indicators identified by all PST members.

10. Consistency with the new training process must occur so that their competencies are clearly stated and that there is a method to determine if staff meet those standards. Verbal testing is not sufficient for the many skills-based tasks required in the implementation of PNMPs and other OT/PT related programs.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o Desensitization plans for: • Individual #500 and Individual #369 o Dental records for the individuals listed in Section L o MSSLC Dental Data, Refusals, October 2010 – January 2011 Interviews and Meetings Held: o John Sponenberg, DDS, Dental Director o Dolores Erfe, MD, Medical Director o Vicki Simmons, RDH o Rose Groth, RDH o Bennie Kirven, Dental Assistant II o Melinda Lopez, Dental Assistant II Observations Conducted: o Dental clinic
	Facility Self-Assessment: The facility's POI for section Q indicated compliance with Provision Q1 and noncompliance with Provision Q2. Observations of clinic, interviews with the staff, and reviews of many documents indicated that some progress had been made. Significant problems were noted regarding the use of pretreatment sedation and a lack of desensitization plans. Suction toothbrushes were limited to those individuals with tracheostomies. The monitoring team must currently agree with the facility's self-assessment of noncompliance.
	Summary of Monitor's Assessment: The dental clinic had made little progress overall in meeting in the items of the Settlement Agreement. This was unfortunate to note particularly since the clinic staff were committed to serving the individuals supported by the facility. This monitoring review was impeded by a lack of information needed to assist in determining compliance with the items of this provision of the Settlement Agreement. For example, only six of 36 document requests were fulfilled. Other items were listed as there being "no information." Problems with management of information and data were identified during the September

	2010 onsite review. The dental director reported that he received no assistance with data generation until two weeks prior to the onsite review and he worked until 7 pm or 8 pm most days just to keep up with charting. The medical director, who supervised the dental director, reported that she was not aware that information had not been submitted. The dental clinic staff included the dental director, two hygienists and two dental assistants. All were long-term employees who were clearly worked in the best interest of the individuals supported by the facility. The clinic started collecting data on missed appointments and refusals and forwarding the data to the home managers and psychologists. The effectiveness of this was not apparent, and certainly had little impact on the development of formal desensitization plans. Oral hygiene in the homes was reported by the staff to be a problem. Many individuals returned monthly for oral care in the clinic. Additional special supports for those at high risk for aspiration were also needed.

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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.	The dental director was the only dentist in the MSSLC clinic. Clinic was conducted daily with the use of three operatories. Basic dental services were provided, including prophylactic treatments, restorative procedures, such as resins and amalgams and x-rays. The dental director reported that clinical demands left little time for data collection, resulting in no production of data related to the various types of procedures done in the clinic. The data submitted for compliance with annual assessments did not provide sufficient data to determine compliance. Fortunately, a new dentist began employment during the week of the onsite review. Documentation of dental treatment was found in the IPN and in the various treatment records. Reviews of records indicated that individuals living at the facility received a variety of dental services and they were seen frequently. During discussions with the dental director and the clinic staff, they reported that oral hygiene in the homes was considered a problem. All new employees received training on providing proper oral hygiene. At each visit, oral hygiene instructions were provided to the individual or the staff that accompanied them. The hygiene ratings for every individual were entered into a spreadsheet and these data were sent to the home managers. The facility did not have any local policy related to the use of special supports for individuals at high risk of aspiration. Individuals who received enteral nutrition had dry	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>toothbrushing and special positioning techniques were utilized. In the record sample reviewed, the dental notes did identify individuals at risk for aspirations and noted the use of safe positioning to minimize aspiration.

Suction toothbrushes were not being utilized and there was no plan to do so.

The dental clinic needed basic operational policy and clinical guidelines. This must be established before a dental quality program can be implemented. The clinic currently had little data related to measurement of its performance, successes, and opportunities for improvements.</td><td></td></tr>
<tr><td>Q2</td><td>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.</td><td><u>Dental Policies and Procedures</u>
The facility had not implemented the current state policy or developed local policy based on the state issued policy. The dental director reported that he was never informed that the policy was approved and ready to be implemented. The clinic staff was not familiar with the policy but stated they used the correct forms.

<u>Failed Appointments and Refusals</u>
Failed appointments and refusals were noted to be a problem and represented a significant barrier in the provision of dental care:

Summary of Onsite Document Request
Failed Dental Appointments October 2010 – January 2011
<table><tr><th></th><th>October</th><th>November</th><th>December</th><th>January</th></tr><tr><td>Missed Appointments</td><td>62</td><td>57</td><td>73</td><td>52</td></tr><tr><td>Refusals</td><td>45</td><td>31</td><td>30</td><td>37</td></tr></table>
The most frequently cited reasons for missed appointments were a lack of staff, individual off campus, illness, and no show.

The dental director reported that data were sent to home managers and psychology related to missed appointments, refusal, and oral hygiene ratings. A request for a list of interventions for failed appointments was responded to with "none." A review of PSP addendums demonstrated that the PSTs were aware of issues related to refusals and failed appointments. In many instances, there were strategies in place to overcome barriers.

<u>Oral Hygiene</u>
Document s containing oral hygiene ratings were not usable in the format provided. In record sample listed in Section L, all dental records were reviewed. All of the individuals were seen frequently in dental clinic. The most recent hygiene ratings showed:</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		• 3 of 12 individuals had good hygiene • 4 of 12 individuals had fair hygiene • 5 of 12 individual had poor hygiene <u>Strategies and Desensitization</u> Record reviews revealed numerous informal desensitization plans. Individuals returned to clinic sometimes weekly or bi-weekly until some measure of success was achieved. This was seen in multiple records. Two individuals had active desensitization plans, Individual #550 and Individual #369. • Individual #500 had a long history of dental clinic refusals and was on once a month recalls increasing the likelihood of a successful dental appointment. The refusals dated back to April 2008 and the reason was unknown. The desensitization plan was implemented 2/1/11. • Individual #369 became uncooperative during routine dental visits but exhibited no problems in transport to clinic. The individual resisted oral hygiene care at home as well. The desensitization plan was implemented 2/2/11.	

Recommendations:

1. The dental department must develop policies and procedures to guide the provision of dental services at the facility. These must be consistent with state issued policy and outline expectations for performance and outcomes.

2. The facility must address the problem of oral care provided in the homes. Consideration should be given to providing training updates directly to all direct care staff. Improving oral are in the homes may result in a diminished need for frequent visits to the dental clinic.

3. The facility should examine further the needs for special supports for individuals at risk for aspiration.

4. The facility must address the issue of failed appointments. This will need to be a collaborative effort between the dental clinic, the PSTs, and residential services. The dental clinic should address failed appointments. The clinic should submit, in writing, a letter that states the appointment missed. The QMRP along with the PST should provide a reason for the missed appointment as well as strategies to complete the appointment. A timeframe for return of this document to dental clinic should be specified. This process should be codified into operational procedure.

5. The facility should develop a formal dental desensitization program and ensure that potential candidates are assessed. When desensitization plans are implemented, the PSP must evaluated effectiveness.

6. The dental clinic must have additional support to ensure that it has the appropriate supports to run a quality dental program and have data to support the quality of the program.

7. The medical director should meet frequently with the dental director to review the provisions of the Settlement Agreement and ensure that progress is being made.

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:** Documents Reviewed: o Clinical Staff list, license numbers and caseloads list o Continuing Education documentation for clinical staff o MSSLC POI for Section R o MSSLC Organizational Charts o Staffing data (2/15/11) o Current Census Counts by Home (3/13/11) o Speech Therapy Progress Record Monitor template o Speech Equipment Monitoring Sheet template o Completed Speech Equipment Monitoring Sheets submitted (February 2011) o OT/PT/SLP Evaluation Update template (draft) o PNMPs submitted o List of individuals with PBSPs and Replacement Behaviors Related to Communication o BSPs for: • Individual #567, Individual #257, Individual #143, Individual #469, Individual #518, Individual #40, and Individual #494 o Communication Master Plan Database (2/9/11) o List of individuals with AAC o Speech Language Evaluation Baseline template o List of completed evaluations o List of individuals receiving direct speech-language services o AAC/Communication curriculum for NEO o Settlement Agreement Cross Referenced with ICFMR Standards Section R template o QA reviews for • Individual #402, and Individual #505 o Communication assessments/updates, PSPs, PSPAs, treatment plans and documentation for: Individual #548, Individual #451, Individual #521, Individual #455, Individual #361 o Communication evaluations/updates and PSPs/PSPAs for: • Individual #109, Individual #252, Individual #367, Individual #273, Individual #248, Individual #306, Individual #149, Individual #89, Individual #455, Individual #361, Individual #302, Individual #131, Individual #301, Individual #60, Individual #143, Individual #578, Individual #151, Individual #84, Individual #203, and Individual #407. o Full medical record for Individual #72 o PSPs, all PSPAs, PBSPs, Physician Annual Medical Reviews, Active Problem List, hospital records, Health risk Assessment Rating Tool, Integrated Progress Notes for 12 months, nursing assessments and quarterlies, documents in Habilitation tab of record, swallow studies, x-ray reports, nutrition assessments, notes and updates, PNMPs (12 months), Dining Plans (12 months), positioning

instructions and pictures, orthotics plans and pictures, other Habilitation Therapy plans, communication plans (none submitted), communication dictionaries, monitoring checklists (three months), weight records/BMI (12 months), and communication-related assessments for the following individuals:

- Individual #435, Individual #40, Individual #38, Individual #542, Individual #79, Individual #293, Individual #477, Individual #143, Individual #285, Individual #369, Individual #188, Individual #321, Individual #432, Individual #494, Individual #469, Individual #567, Individual #328, Individual #518, Individual #151, Individual #503, Individual #257, Individual #16 and Individual #304. There was no evidence of communication assessments for Individual #542, Individual #257 or Individual #304 in the records submitted.

Interviews and Meetings Held:

- SLPs
- Various supervisors and direct support staff

Observations Conducted:

- Living areas
- Dining rooms
- Day Programs

Facility Self-Assessment:

MSSLC's self-assessment identified compliance for item R1 related to an adequate number of SLPs and other professionals. While the facility had provided new contract SLPs (one SLPA and three SLPS) via the Guardian contract with the state, these staff were on a 13-week rotation and three of those weeks had already been spent in NEO orientation. It will take some time for these staff to adjust to the system and to demonstrate competency. The Settlement Agreement provision indicates the facility should provide adequate numbers of staff, but also that they have specialized training and experience "demonstrating" competence in AAC, conducting assessments, developing and implementing programs, providing staff training, and monitoring. As most of these new staff had only recently begun their service at MSSLC, they had not yet had the opportunity to demonstrate competence in these areas. No evidence of their work was submitted in the document request materials. For these reasons, the monitoring team considers this item not in compliance at this time. It will be critical that the facility address the issues of a need for an extended new employee orientation and the fact that the Guardian staff may be short-term only. Significant considerations for longer term retention of staff should be a major focus as well as a well-organized and comprehensive orientation for the department and opportunities for ongoing continuing education and clinical instruction.

The other items of this provision were found not to be in compliance per the facility's self-assessment. This self-assessment was consistent with the monitoring team's assessment of noncompliance. Progress identified by the facility was cited as completion of Priority 1 assessments and scheduled completion of

	Priority 2 assessments by 7/31/11. While they were on track to meet the timeline for completion of assessments, an important aspect of this item also relates to the adequacy of the assessments (comprehensive and appropriate). This was in question at this time as the primary recommendations to date related to the provision of a Communication Dictionary as the primary intervention and the provision of a small number of AAC devices. Most of the assessments to date have been lacking in the design and implementation of training and learning opportunities to enhance and expand existing communication skills. Related to provision R3, the new PSP process had been initiated, but as identified in this report, communication had not been adequately addressed and integrated in new and existing PSPs. The reported 40% completion for this provision appeared to be exaggerated relative to this item as it requires that the PSP "develop and implement assistive communication interventions that are functional and adaptable across settings." The Communication Dictionary addressed the interpretation of the individual's existing communication methods rather than promoting new skill acquisition. A monitoring system per provision R4 had not yet been addressed per the POI. There was no evidence presented for the actions taken to date to address this provision documented in the POI. In relation to actions taken to address recommendations from previous reviews, the action steps, evidence, and target dates were projected to be completed by 9/1/11. The success of this plan hinges on the department's ability to retain contract and state employee staff and to provide adequate support and guidelines to execute these activities in a timely, comprehensive, and competent manner.
	Summary of Monitor's Assessment: As described in Sections O and P above and in this section below, the speech department was dealing with significant issues of transition and instability in the wake of large caseloads and the expectations related to the Settlement Agreement. There was a new department director, existing staff were to be transitioning out, and new staff were transitioning in. There was little change noted since the previous review. The speech staff reported that not all individuals who needed AAC and other communication supports and services received them. One clinician had completed a large number of assessments in her part-time role and all of the Priority 1 assessments were reported to be complete, and a number of Priority 2 assessments as well. There were a small number of AAC systems in place and several individuals were participating in trials to assess the appropriateness of specific higher tech devices. This process was well designed in that it included direct support staff in the training sessions and eventually they would be able to "check out" the system for home or classroom use. Approximately 32.5% (132/405) of the individuals listed in the Master Plan were identified as nonverbal and five individuals had no designation whether they were verbal or nonverbal. The POI reported that 29 individuals were recommended for a Communication Dictionary, only one individual had a high tech communication device, 12 were provided light tech communication devices, and 14 individuals were provided low tech communication devices. The majority of individuals only had a Communication Dictionary that essentially documented how various behaviors were possibly communicative. This was an important support, but did not adequately address potential for skill acquisition over time through regular training and exposure to assistive technology

	throughout the day during meaningful routines. There were less than a quarter of the individuals who were identified with potential to benefit from AAC, who actually had some type of AAC system. Essentially none had active treatment or training supports related to communication. There was generally a very limited focus on expansion of communication skills or new skill acquisition. There were no home or classroom-based SPOs recommended and trials for training AAC for five individuals were not integrated into the PSP via measurable goals. The majority of the AAC systems were portable and intended to be functional in a variety of settings. These were few in number. During observations, devices were not observed in use. Staff did not appear to understand how to use these in programming or functionally throughout the day. Direct support staff and classroom instructors were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred in order to promote communication skill acquisition. A focus on activities designed to promote actual participation, making requests, and other communication-based activities, using assistive technology, is critical. This will require that the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. Another significant concern involved those individuals who may have been more verbal or partially verbal, but exhibited significantly maladaptive behavior that had a foundation in their difficulty with communication skills. These individuals may not be viewed as a priority related to their communication risks, however, significant problem behaviors emphasized the necessity for a strong collaborative approach by PSTs, led by psychology and speech clinicians, in order to develop effective interventions to address these needs.

#	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	**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 review, SLP staffing was in significant transition. There was one full time speech assistant, Jeaneen Abram, SLPA, and two full time contract SLPs who had provided services for the past two years. The contracts for the SLPs were to be reduced to PRN as of 3/31/11. One of these, Cara Mattson, MA, CCC-SLP, had decided to take one of the state SLP positions. There would be two other unfilled state positions. The other SLP, Jean Reboli, MS, CCC/SLP, was to be offered a PRN contract to fill in during vacations by other full time staff. Deanna O'Lenick, MS, CCC/SLP, a part time contract SLP, had reduced her services from two times a week to one time per week as of 12/31/10 and her contract was to be terminated at the end of the month. New full time contract staff were provided by Guardian or sub-contracted through	Noncompliance

#	Provision	Assessment of Status	Compliance
	implementation of programs.	Guardian and included one speech assistant who began on 1/17/11, three SLPs who began on 2/16/11 and one other SLP who was to begin on 3/16/11. Each of these staff had 13-week contracts and there was no certainty that they would or could continue to provide services beyond that time. Limited continuing education related to communication had been attended by three staff as follows since the previous review and included the following: Cara Mattson, MA, CCC-SLP • Dementia Outside the Box (.6 CEUs) on 12/10/10 Jean Reboli, MS, CCC/SLP • Dementia Outside the Box (.6 CEUs) on 12/10/10 Jeaneen Abram, SLPA • Evaluation and Treatment of Individuals with Developmental Disabilities (18 hours) on 9/20 - 9/22/10 • Ethics for SLP and Audiologist (2 hours) on 11/3/10 SLPs were responsible for assessment, supports and services, program development, and monitoring in the areas of communication and mealtimes. There was a potential increase in staffing since the previous review, however, adequate and appropriate communication services had not been provided for the individuals who presented with significant communication deficits at MSSLC as outlined below. Half of the existing speech staff were terminated as of the end of the month of this review and the new staff had only very recently began their employment for MSSLC. It was not possible to evaluate the adequacy of experience, training or competency of the new staff at this time. **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.** Each individual had been previously screened and ranked based on need for AAC. Based on the Master Plan submitted and dated 2/9/11, there were 87 individuals identified as Priority 1, 61 individuals as Priority 2, and 167 individuals as Priority 3. There were another 39 individuals included in the Master Plan with no priority level identified. There were an additional 51 individuals included who were listed as "new," referring to new admissions who were assessed with no other priority level established. Approximately 32.5% (132/405) of the individuals listed in the Master Plan were	

#	Provision	Assessment of Status	Compliance
		identified as nonverbal and five individuals had no designation whether they were verbal or nonverbal. All of the others were identified as verbal. Fifty individuals who were nonverbal had been designated as Priority 2, two were Priority 3, and one had no designation. All others were identified as Priority 1. The Master Plan identified a number of individuals as "complete" under the Priority column. It was not known what this referred to. There were approximately 110 individuals who did not have this designation, primarily those with Priority Level 2 or 3. There were approximately 88 individuals with no communication baseline or update assessment listed as completed within the last two years. Of those, the following individuals were Priority 1: Individual #432, Individual #338, Individual #446, Individual #89, Individual #408, Individual #210, Individual #301, Individual #38, Individual #469, Individual #85, Individual #377, Individual #94, Individual #304, Individual #175, Individual #561, Individual #427, and Individual #70. Seven others were identified as Priority 2 and included: Individual #120, Individual #196, Individual #314, Individual #202, Individual #444, Individual #172, and Individual #226. Two had no priority level identified, two were listed as new, and all others (approximately 60) were listed as Priority 3. Completion of assessments for all priority levels as reported in the POI was not consistent with the Master Plan submitted. During a group interview with the monitoring team, the speech staff reported that not all individuals who needed AAC and other communication supports and services received them. The Master Plan did not identify individuals who required AAC, direct or indirect therapy supports, and interventions. The POI reported that 29 individuals were recommended for a Communication Dictionary, only one individual had a high tech communication device, 12 were provided light tech communication devices, and 14 individuals were provided low tech communication devices. An additional five individuals were involved in trials for high tech communication devices with Deanna O'Lenick. It was not clear what the plan was to continue these trials after the termination of her contract as of 3/31/11. Records of 24 individuals were reviewed as well as communication-related assessments for another 19 individuals. This included individual records requested: Individual #72, Individual #435, Individual #40, Individual #38, Individual #542, Individual #79, Individual #293, Individual #477, Individual #143, Individual #285, Individual #369, Individual #188, Individual #321, Individual #432, Individual #494, Individual #469, Individual #567, Individual #328, Individual #518, Individual #151, Individual #503, Individual #257, Individual #16, and Individual #304. There was no evidence of communication assessments for Individual #542, Individual #257, or Individual #304 in the records submitted.	

#	Provision	Assessment of Status	Compliance
		Also, assessments requested for individuals who received direct speech services included Individual #548, Individual #451, Individual #521, Individual #455, and Individual #361. A sample of five recent communication assessments was requested from each clinician and included: Cara Mattson, MA, CCC-SLP • Individual #109 • Individual #252 • Individual #367 • Individual #273 • Individual #248 Deanna O'Lenick, MS, CCC/SLP • Individual #306 • Individual #149 • Individual #89 • Individual #455 • Individual #361 Jean Reboli, MS, CCC/SLP • Individual #302 • Individual #131 • Individual #301 • Individual #60 • Individual #143 Stacy Catero, MS, CCC/SLP (seasonal contractor) • Individual #578 • Individual #151 • Individual #84 • Individual #203 • Individual #407 Of the assessments reviewed as submitted, 88% (38/43) indicated that the individuals presented with significant communication deficits. Three individuals were reported to be verbal with functional expressive and receptive communication skills, and two others were also verbal with mild to moderate deficits.	

#	Provision	Assessment of Status	Compliance
		It appeared that only 14 of the 41 individuals (34%) for whom assessments were current within the last two years, were recommended for specific communication supports and services designed to improve or augment existing language and communication skills. Assessments submitted for Individual #518 (9/1/95 and 5/21/01) and Individual #79 (12/1/05) were not current within the last 12 months. Use of sign language was to be encouraged for Individual #361 and Individual #40. Trials for AAC use with the SLP were recommended for Individual #548, Individual #361, Individual #451, Individual #455, and Individual #521. Other than these time-limited trials, no direct speech services were recommended for any individuals reviewed. No recommendations were offered for five individuals. In one case, the assessment dated 10/12/10 was incomplete per the copy submitted (Individual #72) and actual recommendations could not be ascertained by the monitoring team. A previous assessment for Individual #72, dated 1/9/09, made no recommendations other than an environmental control device. These devices were recommended for another five individuals, but were not communication-related. Communication Dictionaries were recommended for at least 34 individuals. Additionally, in many cases strategies for staff use to enhance communication skills were outlined in the assessment, but were generally designed to encourage use of existing abilities rather than to promote further skill acquisition in the area of communication. It was of concern that 0% (0/393) of the individuals living at MSSLC received direct communication services as evidenced by the documentation submitted and as reported by the clinicians. Only five individuals were involved in time-limited AAC trials with an SLP. There was no evidence that SPOs designed and monitored by SLPs with implementation by technicians, day program staff, or direct support professionals were in place to expand or enhance existing communication skills for any of the individuals reviewed. Overall, there were at least 132 individuals living at MSSLC who were identified as nonverbal or minimally verbal and were not considered to be functional communicators in a variety of contexts and environments. They had significant communication limitations with likely potential to benefit from AAC supports and services. Per the Communication Master Plan Database, there were approximately 26, or only 20% of, individuals who had potential to benefit from AAC who had some type of AAC system other than a Communication Dictionary. This was consistent with the information reported by the speech clinicians and included in the POI. The types of AAC systems listed in the database submitted included the following: • Super Talker (1), Big Step by Step (2), Big Mack switches (2), Big Talk Triple Play (2), Big Talk (1), Go Talk 4+ (1), Go Talk 9+ (1), Cheap Talk 4 On the go (1), iTalk VOD (1), Magnetic Writing Tablet (1), picture boards (2), communication wallets	

#	Provision	Assessment of Status	Compliance
		(11), activity schedule (1), general object communication system (2), general communication board (1), sign language book/dictionary (2), VI Symbol Communicator (1). A sensory box for Individual #314 was also listed as a communication system. These systems were primarily light/low tech systems and some appeared to be intended to be available to individuals across environments. Most also had a Communication Dictionary for staff reference. Potential for high tech AAC use was limited to those five individuals recommended for trials and included Individual #548, Individual #361, Individual #451, Individual #521, and Individual #455.	
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 five most current SLP assessments with the related PSPs were requested by the monitoring team. Assessments were submitted as follows: Cara Mattson, MA, CCC-SLP • Individual #109 (11/8/10) • Individual #252 (11/22/10) • Individual #367 (12/22/10) • Individual #273 (11/22/10) • Individual #248 (1/31/11) Deanna O'Lenick, MS, CCC/SLP • Individual #306 (12/21/10) • Individual #149 (12/27/100 • Individual #89 (12/21/10) • Individual #455 (1/6/11) • Individual #361 (12/21/10) Jean Reboli, MS, CCC/SLP • Individual #302 (12/21/10) • Individual #131 (10/7/10) • Individual #301 (8/31/10) • Individual #60 (1/4/11) • Individual #143 (1/31/11) Stacy Catero, MS, CCC/SLP • Individual #578 (2/23/11) • Individual #151 (10/27/10)	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #84 (11/23/10) • Individual #203 (12/20/10) • Individual #407 (12/20/10) All of the above were baseline assessments except the assessment for Individual #143, which was an update. PSPs were submitted for only nine of these individuals: Individual #151 (11/15/10), Individual #131 (6/24/10), Individual #143 (2/23/10), Individual #361 (5/5/10), Individual #109 (11/30/10), Individual #273 (12/14/10), and Individual #367 (1/3/11). An incomplete PSP was submitted for Individual #248 dated 3/4/11. Only speech-related PSPAs were submitted for Individual #84 (2/22/11), Individual #203 (2/22/11), Individual #407 (2/22/11), and Individual #302 (2/22/11) rather than their most current PSP. A Discharge Plan was submitted for Individual #301 dated 1/25/11. No current PSPs were submitted as requested for Individual #306, Individual #89, Individual #149, Individual #455, Individual #60, Individual #252, and Individual #578. There were additional assessments submitted as part of the sample records request and included the following: • Individual #72 (1/6/10 and 10/12/10, incomplete) • Individual #40 (8/11/10, incomplete) • Individual #518 (9/1/95 and 5/21/01) • Individual #79 (12/1/05) • Individual #38 (AAC Consult on 6/9/09 and 10/19/09) • Individual #321 (AAC Consult on 6/10/09, 6/28/10 and 1/24/11) • Individual #503 (6/16/10) • Individual #477 (5/2/88 and 9/23/10) • Individual #143 (8/16, 19, 23/10 and 1/31/11, AAC Consult on 4/29/10) • Individual #469 (8/12/09) • Individual #285 (11/30/10) • Individual #435 (6/23/10) • Individual #369 (8/4/10) • Individual #494 (7/20/09 and 11/4/10) • Individual #151 (10/27/10) • Individual #16 (6/14/10) • Individual #293 (10/26/10) • Individual #188 (5/17/10 and 6/2/10) • Individual #567 (9/20/10, incomplete and 9/29/10) • Individual #432 (1/27/10)	

#	Provision	Assessment of Status	Compliance
		Assessments for Individual #542, Individual #328, Individual #257, and Individual #304 were not submitted with their personal records as requested. As noted above, Individual #518 and Individual #79 did not have a communication assessment current within the last two years. Of those current assessments submitted, 16 were identified as baseline assessments and others were identified as updates. Also assessments for those who were involved in direct therapy were requested. There were none at the time of this review, but five individuals were recommended for AAC trials. Assessments for these individuals were requested and submitted as follows: • Individual #548 (9/14/10 and 1/21/11) • Individual #361 (12/21/10) • Individual #451 (9/14/10) • Individual #521 (9/14/10) • Individual #455 (1/6/11) The current assessments were of a generally consistent format. The most current baseline assessments generally included the following subheadings used by Deanne O'Lenick: • Reason for Evaluation Evaluation History Personal Support Plans/Activity Plans Progress Reports • General Information Assessment Procedures Diagnosis and Pertinent History Sensory Information Behavioral Considerations • Communication History Current Method of Communication Previous Evaluations and Treatments Information from Significant Others • Current Test Results Tests/Measures Administered • Receptive and Expressive Language Skills Receptive Language Expressive Language • Pragmatic/Social Communication Skills • Articulation, Voice, and Fluency Skills • Oral Motor Skills • Augmentative/Alternative Communication and Assistive Technology	

#	Provision	Assessment of Status	Compliance
		Switch Access Sites Switch Characteristics Reference system for Choice Making Vocabulary Selection Augmentative/Alternative Communication System Current System Effectiveness • Response to Last Year's Program Services • Clinical Impressions and Implications • Recommendations • Information for the IACT and PNMP Communication Communication Equipment Communication Focus Communication Strategies • Speech Handicap Care Level • Next Speech Language Evaluation/Update The most current updates generally included the same subheadings as those listed above and made reference to the previously completed baseline assessment. As described above, a comprehensive assessment was reported to have been provided to all of those individuals identified as Priority 1 (100%). By report, there were approximately 35 more individuals identified as Priority 2 who required assessment. Two of the individuals (Individual #518 and Individual #79) reviewed had not received an assessment since 5/21/01 and 12/1/05 respectively. Though by report, the clinicians planned to provide a comprehensive assessment every three years with updates in the interim. Individual #432 and Individual #469 had not received updates in the last 12 months. Individual #469's baseline assessment was 19 months earlier and Individual #432's was nearly 14 months ago. Overall, there were approximately 233 individuals that appeared to have no current communication assessment per the Master Plan submitted. There were 16 of these who were classified as Priority 1, 25 individuals classified as Priority 2, and 164 who were classified as Priority 3. This was in contrast to the report that all Priority 1 assessments had been completed and that there were approximately 35 left to do who were Priority 2. The baseline assessments were generally comprehensive in nature, though recommendations were limited as noted above. Most individuals were recommended for a Communication Dictionary only. At the time of this onsite review, it was reported that not all individuals with a need for an AAC device had been identified to date. There was	

#	Provision	Assessment of Status	Compliance
		generally very limited focus on expansion of communication skills or new skill acquisition. There were no SPOs recommended or implemented that were developed or monitored by the SLPs. **Standard: All people received a communication screening or assessment within 30 days of admission, readmission, or change in status.** Per the list submitted, there had been 17 admissions to MSSLC in the previous six months. Individual #273, Individual #109 and Individual #367 were included in the sample reviewed. They each had received a communication assessment within the 30-day timeframe. Individual #109 had not been included in the Master Plan submitted however. Per this Plan all others had received an assessment within 30 days with the exceptions of Individual #31, Individual #42, and Individual #294. There was no evidence that an assessment had been provided for them. In the case of Individual #432, an 86-year-old woman, she received a baseline assessment, dated 1/27/10, after referral for a "change in condition." This was not listed in the Master Plan, however. Per this evaluation, she had previously been a functional verbal communicator and was essentially nonverbal at that time. Verbalizations were unintelligible and she mumbled in a very low vocal intensity. The assessment did not provide any timeframe in which this change had occurred, nor was there any explanation of why this change in function had occurred. The only recommendation was to provide a Communication Dictionary because she was nonverbal. As stated above, she had not received a subsequent assessment update in nearly 14 months. **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** • **The need for further assessment in Augmentative Communication.** Each of the comprehensive assessments reviewed generally addressed both verbal and nonverbal skills and expressive and receptive language 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. There were no recommendations for training objectives for any of the individuals for whom current assessments were submitted and reviewed (41), though all but a few were described with severe communication deficits. Each of the assessments	

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		or updates included a section of Communication Strategies that tended to focus predominately on what staff could do to ensure that their communications were more readily understood by the individual and did not generally address expansion or development of expressive communication skills. There was very limited evidence of more specific interventions intended to specifically increase communication skills through structured clinician-designed programs and interventions. **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.** Individuals were to be provided an assessment based on the Master Plan, per the prioritized schedule. The intended plan was to provide re-evaluation every three years for each individual with interim updates on an annual basis for those who received supports and services. The intent of the interim update was to review the individual's status and the relevance and appropriateness of the supports provided. Most of these had been completed in the last year and it was not possible to assess the consistency of re-assessment to review the adequacy of the supports provided. As described above, there were very few individuals who received indirect services beyond a Communication Dictionary and no one had received direct communication services. **Standard: Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.** There were no SPOs or interventions provided or designed by the SLPs. **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.** There was no policy or assessment/screening to identify those who received behavioral supports and interventions, such as a PBSP, and would benefit from AAC or other communication-related interventions. There were at least 14 individuals included in the sample who had PBSPs with communication-related behavioral concerns. There was generally a reference to these plans in the communication evaluations. There was little to no analysis of the relationship of communication to these behavioral concerns and there was no evidence of collaboration with psychology in the communication assessments, though it was reported that they did this on the phone.	

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		Standard: Communication programs were integrated into the BSP as indicated. In the assessments reviewed for individuals with PBSPs, the SLP identified the target behaviors of the plans, but as stated above, did not provide any discussion as to the relationship of behavior and communication skills. There was no evidence that there had been actual collaboration between psychology and the SLPs in the development of PBSPs or in the development of skill acquisition plans to address individual needs as they related to communication. For example: • Individual #257: She was reported to display aggression to others and attempted to bite, hit, kick, scratch or push others. She also threw things, cursed, yelled, or engaged in very loud vocalizations. She was also reported to be blind. Her PBSP outlined that staff should provide sensory stimulating activities such as conversing with staff or engaging in sensory stimulating objects. There was no evidence of a communication assessment in records submitted or listed as completed in the Master Plan database. • Individual #143's PBSP documented that she likely engaged in self-injurious behavior to gain attention from staff or to gratify sensory stimulation needs. Her communication assessment dated 1/31/11 did not even mention that she had a PBSP. She was reported to use a Super Talker 8 grid overlay, but it was determined that she should have a two month therapeutic trial with the device. This device was not mentioned in her PBSP. Her PSP dated, 2/1/11, reported that she was nonverbal and could not make her wants and needs known to others (behavior/psychiatry heading). She also responded to some yes/no questions, but it was questionable as to what she actually understood. The Speech/Audiology section referenced the Super Talker, but did not identify her actual expressive and receptive abilities in a functional manner. A service objective was listed for speech to provide required assistance related to her communication devices and was to provide assessments at least annually. There was no SLP present at her PSP meeting. The concept of the trial recommended in the assessment was not addressed during the PSP. Her previous baseline assessment reported that she did not use the Super Talker with consistency, yet there had been no formal programming supports to promote skill acquisition. Instead it was merely made available to her and staff were to encourage its use. • Many others who were currently a Priority 2 or 3 were verbal, yet presented with significant challenging behaviors that would benefit from collaboratively designed and implemented supports, interventions and programming.	

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		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 Master Plan recorded completion of assessments. The plan was intended to prioritize those individuals who would most benefit from AAC devices or equipment. AAC provided to individuals was to be listed in the Master Plan as well. There was no facility policy that outlined the communication assessment schedule, guidelines to prioritize assessments, or that established specific staff responsibilities.	
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: The PSP contained information regarding how the person communicated and strategies staff may utilize to enhance communication.** The information contained in the PSPs related to communication was extremely inconsistent across the plans reviewed. Only a few of the PSPs submitted with this sample were of the new format and the potential for improved descriptions was noted, but was not well implemented at this time. There was more information related to the individual's communication skills in the behavioral portions of the plan than in the portion designated as Speech/Audiology. For example, in the case of Individual #367, it was reported only that he was verbal in his PSP, yet there were references when staff should reinforce him for verbal problem-solving or using "I feel" statements. In the case of Individual #548, his communication abilities or how staff could enhance his communication skills were not identified. There was reference only to his need for a new communication device, iTouch, and that it was pending approval. The only action steps related to communication were that speech would continue to assess and train related to his AAC. There were no communication-related training objectives identified by the PST. The only other PSP (Individual #248) that was of the new format submitted was blank though the meeting had been held on 2/16/11. **Standard: AAC devices were portable and functional in a variety of settings.** The majority of the AAC systems recommended were portable and intended to be functional in a variety of settings. There were no instructional plans submitted to guide staff implementation or support of the devices issued to individuals per the Master Plan. During observations, there were only a few devices that were observed in use. There were a number devices noted in the day program areas and staff referred to	Noncompliance

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		"communication time" when the individuals were encouraged to use the device rather than implemented in a manner that was functional throughout the day. For example, Individual #175 had a voice output switch that said "come here" and "what's up." There were no specialized instructions available for staff to direct how to use the device, but rather the staff merely encouraged her to hit the switch during a specified training period. In another day program area, the staff described that they talked about the picture wallboard rather than used to it allow individuals to express a request. When asked about this, the staff indicated that they did occasionally move the individual near the board. The monitoring team noted, however, that the board was located in a place on the wall and that the individuals could not actually access the board or point to or touch any of the pictures. **Standard: Communication programs and AAC devices were individualized and meaningful to the individual.** The existing AAC systems, though few in number, appeared to be individualized and there was an obvious effort to make them meaningful as well. The assessment process was more comprehensive, though there were a number of individuals who had not yet received an assessment. The absence of individualized formal training regarding communication and language continued to be a serious problem at MSSLC. **Standard: Staff were trained in the use of the AAC.** Direct support staff were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred in order to promote communication skill acquisition. There were no formal communication programs. There was no evidence that staff received individual-specific training related to the Communication Strategies identified in the assessments or competency-based training related to AAC or environmental control devices issued to individuals. There were no instructional plans submitted or observed as available for AAC use. The Communication section of the PNMPs provided more specific information about how the individuals communicated, in some cases. There continued to be very limited instruction as to how staff could support or enhance both expressive and receptive language. As described above, staff did not demonstrate a good understanding of how to promote language or communication opportunities in the daily routine or during structured programming throughout the day. **Standard: Communication strategies/devices were implemented and used.** There were few AAC systems observed being used throughout this onsite visit. Much of	

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		the interaction observed by the monitoring team was specific to a task with little other interactions that were meaningful, such as during a meal. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be made a priority. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. **Standard: General AAC devices were available in common areas.** A few community-use devices were available in the homes. These non-portable devices may be useful as a backup or extra system for individuals, but should not be used as a primary augmentative or alternative means of communication for an individual. None of these were observed in use during the onsite review by the monitoring 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.** There were no policies related to a monitoring system for AAC. The SLP assistant conducted monitoring that addressed availability and working order of AAC only. The SLPs should have routine and frequent responsibilities to monitor communication programs beyond the annual assessment or requests and referrals to assess actual use of the devices issued as well as the effectiveness for the individual. Devices observed in a classroom in the Martin unit were not in working order and were difficult for the classroom instructor to activate let alone the individuals for whom they were intended (Individual #538 and Individual #26). **Standard: Monitoring covered the use of the AAC during all aspects of the person's daily life in and outside of the home.** Quality assurance monitoring was completed routinely**.** Samples of these were submitted as requested and included Individual #402 and Individual #505. In the case of Individual #402 (February 2011), it was reported that there was no integration of communication supports in the PSP. An AAC device had been implemented but there had been no PSPA nor was there a re-assessment prior to the annual staffing. The device was not referenced in the PSP. The device was intended for classroom use yet there were no SPOs written for this training nor were there instructions in his PNMP book. Individual #505 had not received a communication assessment since 2001. He was listed as	Noncompliance

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		Priority 2 and had been scheduled for assessment by 7/7/10, though as of January 2011, he had yet to receive one. He was reported to be nonverbal. Monitoring of AAC appeared to be generally conducted in the homes rather than across settings. Monitoring was conducted by the SLP assistant and focused on availability of AAC and whether it was in working order. The monitoring sheets for the last month indicated that instructional sheets were available for the systems issued, though these were not consistently available as observed by the monitoring team. There was no evidence of routine monitoring of implementation or efficacy of the systems provided. **Standard: Validation checks were built into the monitoring process and conducted by the plan's author.** There was no validation check provided for monitors at the time of this review. Further assessment of this element will be necessary in future reviews.	

Recommendations:

1. Develop a clearly delineated plan to address staff retention, orientation supports, and continuing education.

2. Provide assessment and collaboratively (PSTs guided by psychology and speech clinicians) designed and implemented supports, interventions, and active programming for individuals who were currently identified as Priority 2 or 3 and verbal, but presented significant challenging behaviors.

3. Assessments must provide a clearly stated and thorough rationale as to why or why not AAC is determined to be appropriate for an individual. Actual trials of certain systems may be needed to more thoroughly explore this. Greater specificity is needed to describe the clinical reasoning process used by the therapist to select a particular device. These are key elements to a comprehensive assessment that meet generally accepted professional standards of care.

4. For those receiving direct services, well defined, measurable, meaningful, and functional goals or outcomes must be clearly stated with indices of progress reviewed no less than monthly. Modifications to intervention plans must be made when lack of progress is noted. Ensure all of these are integrated into the PSP process.

5. There is a significant need to develop programs to address increasing or expanding language skills, ability to make requests and choices, and other basic communication skills. Formal programming is indicated for a number of individuals. Speech staff should also model more informal ways to promote interaction and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs.

6. Consider expanding the NEO training to address AAC, and also to teach staff to understand how to be an effective communication partner. As

AAC is developed, it then becomes a method much like speech, rather than a unique entity in which the functional purpose becomes lost on staff. When that happens, it loses meaning for them as well. It becomes a "task" and is not integrated into the individual's daily routine.

7. Many recommendations appeared to be left to the PST for the development and implementation of plans, even in the absence of sufficient staff training. 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 training, 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.

8. Routine monitoring needs to include a review by professional staff as to the effectiveness of AAC systems, as well as formal and informal programming rather than only availability and condition of existing systems.

9. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs.

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 #492, Individual #82, Individual #508, Individual #589, Individual #113, Individual #519, Individual #514, Individual #450, Individual #271, Individual #408, Individual #132, Individual #31, Individual #164, Individual #471, Individual #6, Individual #249 o Specific Program Objectives (SPOs) for: • Individual #342, Individual #169, Individual #152, Individual #175, Individual #94, Individual #248, Individual #31, Individual #519, Individual #56, Individual #57, Individual #481, Individual #335, Individual #456, Individual #369, Individual #500 o Six months of master teacher data and progress notes for: • Individual #410, Individual #181, Individual #154, Individual #533, Individual #145, Individual #126, Individual #285, Individual #411, Individual #157, Individual #383, Individual #519, Individual #441, Individual #491, Individual #143, Individual #589, Individual #492, Individual #514 o List of individuals who are employed on- and off-campus, undated o Summary data and graphs of community outings per individual/home, 1/10-1/11 o List and graph of all instances of skill training provided in the community, 1/20/11-1/28/11 o List of master teacher training on skill acquisition programming, 9/15/10-1/15/11 o Skill acquisition monitoring tool, 12/10 o Engagement monitoring tool, 9/29/10 o List of individuals who were under age 22 and their school assignment o Observational monitoring sheet for MISD on campus classrooms, January 2011 to March 2011 o IEP, IEP progress notes, MSSLC SPOs, and PSPs for • Individual #183, Individual #473, Individual #475 <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 MISD public school classrooms at MSSLC o Observations occurred in various day programs and homes 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 in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings of noncompliance in all areas.
	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 items of this provision of the Settlement Agreement were found to be in substantial compliance, there were several improvements since the last review. These include: • Systematic collection and analysis of individual engagement • Development of a SPO monitoring tool, and the systematic analysis of associated data • Modification of skill acquisition plans • Improvement in the documentation of the rationale for SPO selection • Development of a data system to track and improve training of individuals in the community • Improved individual engagement scores The monitoring team is encouraged by MSSLC's approach to improving individual engagement, SPOs, and training in the community by establishing tracking systems, monitoring those data, and making decisions to modify plans/procedures based on the results of their data. At the same time, the facility is reminded that the collection and analysis of data is a tool for achieving the ultimate objective which is too ensure that all individuals are engaged in meaningful activities, and that SPOs are consistently practical and functional.

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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 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.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at MSSLC. The facility continues to make steady progress, however as indicated below, more work needs to be done at the facility to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision item. <u>Skill Acquisition Programming</u> Personal Support Plans (PSPs) reviewed indicated that all individuals at MSSLC had multiple skill acquisition plans. These plans consisted of training objectives, referred to as specific program objectives (SPOs) that were written and monitored by master teachers. SPOs were implemented by education and training instructors and direct care professionals (DCPs). As discussed in the last report, an important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, psychological assessment, and individual preference. 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. The facility has made some progress in this area since the last review. The SPO training instructions sheet has been modified to include the justification for training and individual preferences. For example: • Individual #342's SPO for increasing independent living skills included the following justification/rationale: "The following SPO was developed from (Individual #342's) preferences which were based on his Positive Assessment of Living Skills (PALS) and Functional Work Behaviors Assessments which were noted at his PSP on January 05, 2011. • Individual #169's SPO for increasing independent living skills included, "(Individual #169) and his PST developed his SPO based on his preferences and needs which were prioritized for the following training objectives and goals to better prepare him for community placement." The monitoring team was encouraged by this addition to the SPOs that clearly stated that each SPO was based on each individual's preference and needs. It is recommended, however, that the justification/rationale for the selection of each individual's SPOs be more specific. For example, the justification/rationale for the training section should include the specific need (e.g., lack of independent leisure skills as measured by adaptive assessment or specific task analysis), and specific preference (e.g., watching TV) that lead to the selection of this specific SPO (e.g., learning to independently turn on, select the preferred channel, and turn off the TV).	Noncompliance

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		Please see sections F and T for additional comments regarding the determination of objectives. Once identified, 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 This is another area where MSSLC continued to make improvements. An SPO monitoring tool was recently developed to ensure that the above components have been included. Additionally, a data system to track the percentage of necessary training components was developed. Nevertheless, review of SPOs revealed that some of the above components continued to be absent. For example Individual #152's money skills SPO (i.e., complete a deposit slip) did not appear to have a clear description of teaching behaviors, relevant discriminative stimuli, specific consequences for correct responding, or a plan for maintenance and generalization. It is recommended that the facility continue to work to ensure that all of the above components are included in each SPO. The facility reports that it continues to investigate additional training methods and was awaiting the development of a new policy in this area. It is expected that the policy will provide direction and guidance. <u>Desensitization skill acquisition</u> As discussed in the last report, dental desensitization programs were recently being developed and monitored by the psychology staff at MSSLC. These skill acquisition plans were to teach individuals to tolerate dental interventions, and can result in a decrease in the use of sedating pre-examination medication. Five of these plans (for Individual #481,	

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		Individual #335, Individual #114, Individual #369, and Individual #500) were reviewed by the monitoring team. These SPOs contained the majority of the necessary components listed above. Some components, however, were not apparent to the monitoring team. For example, Individual #481's dental desensitization SPO did not consistently use operational definitions of target behaviors (e.g., for being upset) and specific instructions (e.g., the SPO states that additional steps will be added at each visit, but did not specify criterion for adding those steps). Nevertheless the addition of the dental desensitization SPOs represents an improvement. Initial reports suggest that the facility's use of sedating medications for routine dental procedures had been reduced. Specific outcome data from these SPOs will be reviewed in more detail in future site visits. <u>Replacement behaviors from PBSPs as skill acquisition</u> MSSLC included replacement behaviors in each PBSP. There were some descriptions of teaching conditions, however the format was not consistent and the quality and detail of the training varied greatly (see K9). It is recommended that replacement behavior training procedures be incorporated into the general training objective methodology (i.e., written as SPOs), and conform to the standards of all skill acquisition programs listed above. <u>Communication and language skill acquisition</u> The monitoring team found only a few acquisition programs targeting the enhancement or establishment of communication and language skills (e.g., Individual #175' receptive communication SPO). It is recommended that the facility expand the number of communication SPOs for individuals with communication needs. Also please see section R of this report. <u>Service objective programming</u> The facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). These were typically written and monitored by the QMRPs. The monitoring team did not review these plans in this provision of the Settlement Agreement because these were not skill acquisition plans (see provision F for a review and discussion of service objectives). <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	

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		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. As reported in the last review, the monitoring team was encouraged by the overall quantity of age appropriate and typical activities at MSSLC. Consequently, in several homes visited, many of the individuals were out of the homes, engaging in activities (e.g., playing basketball, at the gym). 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 individuals did not possess the skills to readily engage in independent activities, the ability to maintain individuals' attention and participation in activities varied widely across staff and homes. The table below documents this variability across settings. The average engagement level across the facility was 59%, an increase over that observed during the last review (i.e., 51%) and the same as that observed during the baseline review. 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 these tools and will review the facility's engagement data on future reviews. The importance of ensuring that there are numerous activities and opportunities for engagement can play a positive role in reducing behavior problems, teaching new skills, and increasing satisfaction (also see sections C, D, and F). <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
M1	2/3	2:3
M3	1/9	3:9
M4	1/5	2:5
M4	1/4	1:4
M2	1/3	1:3
M2	2/2	1:2
M5	1/3	1:3

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M5	1/2	0:2
W1	5/6	3:6
W2	1/2	1:2
W3	4/4	1:4
W4	3/4	2:4
W5	4/5	2:5
W6	1/6	2:6
L3	7 /7	2:7
L4	2/4	3:4
L6	3/3	2:3
S4	1/2	1:2
L1	3/6	2:6
S1	3/5	2:5
S2	0/5	2:5
B1	1/2	2:2
B3	1/4	1:4
STEP Center	10/10	2:10
C7	1/1	1:1
W8	1/2	2:2
W8	2/4	3:4
Workshop	7/8	3:8
Workshop	6/7	3:6
STEP Center	8/10	4:10
STEP Center	2/5	3:5

Educational Services

Progress in the development of a good working relationship with Mexia Independent School District (MISD) continued. It was spring break during the week of the onsite review, so the monitoring team was not able to observe school in session. The monitoring team, however, did tour the MISD classroom and school area on the MSSLC campus.

The MSSLC liaison to MISD noted that 11 students were at the high school, 27 were at the MISD developmental center, and 36 were at the MISD school on the MSSLC campus. Thus, more students were off campus at MISD than remained on campus. It appeared that the intention of MISD was to have as many students as possible attend school in public school buildings.

The MSSLC liaison to MISD attended all of the ARD/IEP meetings, often the QMRP also

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		attended. MISD staff rarely attended MSSLC PSP meetings, however, the MSSLC liaison noted that they were attempting to have the MISD behavior specialist attend PSP meetings when important behavioral issues were to be discussed. MSSLC had made some nice efforts towards integrated learning activities from school into on campus programming. For example, the education and training department had developed SPOs to correspond with some MISD IEP objectives. The monitoring team learned, however, that some students complained about having to do "schoolwork" during school holidays and vacations. Doing schoolwork at home (i.e., homework) is a very typical activity for all children and adolescents who attend school, whether they live in a facility, in foster care, or with their family. The SPOs, IEPs, and PSPs for three individuals were reviewed by the monitoring team (see list above under Documents Reviewed). Each PSP made reference to the individual's IEP. MSSLC initiated, in January 2011, a one page observational tool for monitoring and recording some of the activities going on at the on campus classrooms. These were conducted by the liaison, a number of different QMRPs, and by the QA department staff. This was great to see. The data should be summarized and included in the facility's QA program, too. The MSSLC liaison reported that he had some discussion with MISD regarding the appropriateness of extended school year programming. MSSLC should continue to advocate for extended school year programming for those individuals for whom it would be appropriate.	
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, the facility was beginning to make improvements in the documentation of how this information impacted the selection of specific program objectives. Overall, however, more work is needed to achieve substantial compliance for this item. 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. Finally, MSSLC had been using PALS for the assessment of individual skills, and as part of the method of identifying skills to be trained. DADS was in the process of evaluating several assessments as an alternative to PALS. The monitoring team is supportive of the identification of an alternative to PALS, and looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing,	Noncompliance

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		speech/language pathology, etc.) and individual preference, to identify meaningful individualized skill acquisition programs.	
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 and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	The facility continues to be progressing on this provision item. More work in the areas of integrity of the implementation and the practicality and function of SPOs is needed. Therefore this item was rated as being in noncompliance. As discussed in the last report the master teachers at MSSLC graphed SPO data to improve data-based decisions as to continuing, modifying, or discontinuing individual SPOs. 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 #383; calculation of the balance in his saving account for Individual #411). Additionally modifications in training were specified for SPOs that were not progressing (e.g., Individual #410's telling time, Individual #533's counting contract work). The skill acquisition plans at MSSLC were clearly practical and functional for some individuals (e.g., teaching Individual #143 to push a button on her communication book), however, some individuals appeared to have similar goals (e.g., using the vending machine). For many others (e.g., measuring one cup for Individual #519) it was not clear how or why these are practical without a specific rationale as recommended in S1. The monitoring team is encouraged by MSSLC's systematic approach to making data-based decisions to continue or modify SPOs. The facility, however, also needs to ensure that SPOs are consistently practical and functional. MSSLC recently introduced integrity measures to ensure that SPOs were implemented as written. Future onsite reviews will examine these data. The monitoring team observed the implementation of SPOs in several day programs and homes during the onsite review to evaluate if SPOs were implemented as written. Additionally, SPO data sheets were also reviewed to evaluate if data were completed as scheduled. The results from those observations were mixed. For example: • Individual #398 was working on his SPO of counting coins and writing his name.	Noncompliance

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		The DCP appeared to implement the acquisition programs as prescribed in the teaching methodology/task analysis steps. Additionally all SPO data were completed. • Individual #524was observed working on her money skills SPO. The SPO indicated that she was to insert coins in a vending machine; however, the DCP was only asking Individual #524 to point to the coins. These observations suggested that SPOs were not conducted with integrity at the facility, and that more work is needed to insure that SPOs are conducted with integrity.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at MSSLC enjoyed various recreational activities in the community. The facility had begun to make progress in providing and documenting the occurrence of training in the community that address specific needs for services or preference. This process had recently begun and could not be fully evaluated at the time of the onsite review, therefore, this item was rated as being in noncompliance. Since the last review, the facility has begun to track community integration. This report recorded training activities in the community for each individual. These activities included training objectives, such as socialization and turn-taking, in addition to specific SPOs (e.g., purchasing items). Data from January 2011 (when tracking began) indicated that 47% of individuals at the facility were engaged in community-based training. In order to better track trends, it is recommended that the report be modified to specifically indicate if an individual's community activity represented an incidental training activity (e.g., socialization), or the implementation of a specific SPO (e.g., purchasing an item from a store). At the time of the review, 27 individuals at MSSLC worked in the community. This was consistent with the number reported during the last onsite review. The monitoring team was encouraged by the facility's progress on this provision item and look forward to seeing continued progress at the next review.	Noncompliance

Recommendations:

1. It is recommended that the facility more specifically document how SPOs are based on individual needs and preference.
2. The facility should ensure that all of the components necessary for learning new skills are included in each SPO.
3. The facility should continue to explore additional training methodologies and systems.

4. Replacement behavior training procedures should be incorporated into the general training objective methodology (i.e., written as SPOs), and conform to the standards of all skill acquisition programs listed above.

5. It is recommended that the facility expand the number of communication SPOs for individuals with communication needs.

6. The facility needs to ensure that all individuals are engaged in meaningful activities and that SPOs are consistently practical and functional.

7. Ensure that SPOs are conducted with integrity.

8. It is recommended that the community integration report be modified to specifically indicate if an individual's community activity represented an incidental training activity (e.g., socialization), or the implementation of a specific SPO (e.g., purchasing an item from a store).

9. Continue to explore extended school year for those individuals for whom it would be appropriate.

10. Include observational data from the on campus classrooms in the facility's QA program.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and attachments (exhibits) o DRAFT revised DADS SSLC Policy: Most Integrated Setting Practices, and attachments o Organizational chart, 2/15/11 o DADS Obstacles Report for SSLCs, October 2010 o MSSLC policy lists, 2/17/11 o MSSLC new or updated policies related to most integrated setting practices • Administrative-21, Placement reviews and appeals (updated) • Committees and Counsels-39, Placement review team (new) o List of typical meetings that occurred at MSSLC o MSSLC POI, 2/24/11 o MSSLC Admissions and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/14/11 o Community Placement Report, through 3/15/11 o List of individuals who were referred for placement and had been placed since 9/1/10 and through 3/14/11: • 23 individuals • 28 individuals listed in Community Placement Report • 63 individuals at time of last review (listing was for an eight-month period) o List of individuals who were referred for placement since 9/1/10 and had not yet been placed as of 2/25/11 • 18 individuals • 44 individuals at time of last review (listing was for an eight-month period) o List of individuals who were referred since 7/1/09 and had not yet been placed as of 2/25/11 • 73 individuals • 64 individuals listed in Community Placement Report o List of individuals who had requested placement themselves, but were not referred, February 2011 • 168 individuals (some were now on the referral list) • 104 individuals listed in Community Placement Report • 40 individuals at time of last review o List of individuals who had requested placement themselves, but were not referred solely due to LAR preference • 10 individuals

	• Four individuals listed in Community Placement Report o List of rescinded referrals • 21 individuals listed in Community Placement Report o List of alleged offenders through 2/17/11 • 159 individuals • 162 individuals at time of previous monitoring review o List of individuals who had returned from a community placement • One individual • Summary of events, readmission PSP o List of individuals discharged under alternative discharge process since 9/1/10 • Three individuals • Four individuals at time of previous monitoring review • Discharge packets of information for the individuals discharged under the process for alternate discharges 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 (the list did not indicate the reason for the individual not being referred) o MSSLC community placement obstacles, 9/14/10 through 2/21/11 o Attendance at MSSLC provider fairs 2008, 2009, and 2010 o Listing of individuals who went on tours 9/9/10 through 2/17/11 (46 names, two went on two tours) o Listing of 24 tour dates 9/9/10 through 2/25/11 and notes from most of the tours o Documents related to training session on 11/19/10 regarding community placement processes o Documents related to presentation made by APC at family association meeting, 1/30/11 o List of individuals who have had a CLDP developed since 9/13/10 • 26 individuals • 65 individuals at time of last review (listing was for an eight-month period) o Table showing that a APC department transition specialist attended the meeting during which the referral was made (or if not in attendance, the date, within two weeks during which this meeting occurred) o Table showing how supports were to be evidenced and/or verified from 17 recent CLDPs o Checklist used by APC to track that all assessments (12) are submitted, and completed checklists for seven individuals o DADS MSSLC family satisfaction survey online summary, nine respondents o Agenda and materials from DADS statewide conference call with APCs from all SSLCs o Minutes/notes from MSSLC placement review team meetings regarding 17 individuals. Thirteen of these individuals were reviewed during one meeting on 2/17/11, the other four were reviewed during individual meetings in late 2010. o PSPs for: • Individual #497, Individual #313, Individual #401, Individual #383, Individual #132, Individual #441, Individual #53, Individual #226, Individual #356, Individual #251, Individual #548, Individual #342, Individual #249, Individual #6

	o CLDPs for: • Individual #41, Individual #292, Individual #408, Individual #271, Individual #450, Individual #240, Individual #467, Individual #111, Individual #298, Individual #166, Individual #180, Individual #509, Individual #232, Individual #294 o CLDPs in progress for: • Individual #232 o List of post move monitoring dates due and completed. o Post move monitoring checklists conducted since last onsite review for: • Individual #584: 7-day, 45-day • Individual #277: 7-day, 45-day • Individual #81: 7-day • Individual #83: 7-day • Individual #240: 7-day • Individual #292: 7-day • Individual #41: 7-day, 45-day, 90-day o Unusual Incident Investigation regarding MSSLC PMM and PST concerns and issues regarding the placement and supports being provided to Individual #480 in his community placement o Post move monitoring checklists for four individuals who have died in January 2011 and February 2011 after moving to the community less than one year prior • Individual #480, Individual #312, Individual #495, Individual #513 o Post move monitoring checklists two individuals conducted by other SSLCs for: • Individual #573, Individual #59 o Completed self-monitoring tools for most integrated setting practices; three different tools, varying numbers per month, October 2010 to March 2011 <u>Interviews and Meetings Held</u>: o Alynn Mitchell, Admissions and Placement Coordinator o Donnie Wilson, DADS Central Office Continuity of Services Coordinator o Dr. William Lowry, Facility Director o Brenda Shoemake, Assistant Director of Programs o Joy Lovelace, PSP Coordinator o Dr. James Simpson, owner, Ruth Marie's Country Homes o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs <u>Observations Conducted</u>: o Statewide conference call for all APCs, 3/17/11 o PSP Meeting for: • Individual #249, Individual #6 o PSPA Meeting for: • Individual #389

	o CLDP meeting for: • Individual #232 o Community group home visit for: • Individual #41 o Many residences and day programs at MSSLC
	Facility Self-Assessment: The facility's self-assessment, its POI, was revised and simplified compared to the POI presented during the previous onsite review. This was an improvement and should provide the admissions and placement department with guidance and direction. The POI was dated 2/24/11, about three weeks before the onsite review. The monitoring team recommends that the department use the information provided in this section of the report to revise the content of this POI. Many comments, feedback, recommendations, and suggestions are provided below. It would make sense for the APC to use this report to guide her in setting forth a set of actions to work towards achieving substantial compliance with this provision. The POI indicated a self-rating of substantial compliance with 10 provision items. The monitoring team did not agree with most of these self-ratings. The monitoring team rated only four of these 10 as being in substantial compliance. The differences appear to be based upon what the APC was using as criteria to score "Yes" ratings on the facility's self-monitoring tools for most integrated setting practices. The APC should compare the ratings with the details provided in the report below. It may be that the APC considered the presence of an item or document rather than the quality and adequacy of the contents of those items and documents. This may help the APC and the facility to create criteria that are in line with the monitoring team's expectations of what is required to achieve substantial compliance. T1e provides an especially salient example. The monitoring team found this to be an area of poor performance for the facility, yet the POI indicated this was in substantial compliance. It appeared the facility's rating was based on there being essential and nonessential supports listed in the CLDP. As detailed below in T1e (and somewhat in T1a) the breadth, quality, and individualization of these lists of supports was inadequate and resulted in a monitoring team rating of noncompliance. On the other hand, the facility self-rated itself as being in noncompliance with provision item T4, however, the monitoring team rated this as being in substantial compliance. 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. The APC's presentation book contained a lot of relevant information.
	Summary of Monitor's Assessment MSSLC continued to engage in many activities to encourage and assist individuals to move to the most

	integrated setting. Funding did not appear to be an obstacle to any individual's transition. The number of individuals placed in the community had decreased over the past year. The facility director noted that this was due to the facility implementing a slower and more conservative process in making placements. This was a sensible way to approach placements, given the complex needs of most of the individuals referred for placement. There were problems, however, with a number of MSSLC placements over the past year. Although they were a small percentage of the total number of community placements made by the facility, each one should be thoroughly reviewed and studied so that similar problems might be avoided in the future. This is especially important because, given the challenging and complex histories of many of the individuals being placed by MSSLC, a single failed community placement could have a chilling effect on the facility's (and DADS') ability to place individuals (e.g., if there is an injury to an innocent member of the community). The opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required (this was what was noted in the previous monitoring report). Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. The facility had begun to address education of individuals and their families on an individual basis. This was demonstrated during the PSP meetings and documented in the written PSP. The APC engaged in a number of training activities, including a session for the family association. The facility took individuals on visits to community providers. The facility had made progress in organizing its system of planning, documenting, and reporting. Fourteen CLDPs were reviewed and were found to be surprising similar, if not identical. The lack of individualization, especially in the listing of essential and nonessential supports was a serious problem. Further, the lists of supports in the CLDPs were inadequate. Problems in identifying essential and nonessential supports were identified in the baseline monitoring report and again the previous monitoring report. Almost every individual had only two or three essential supports and they were almost identical in every case. Most of the supports required the provider to be trained on aspects of the individual's care (e.g., PBSP, PNMP), but failed to list the important components as separate supports. The required evidence did not include detail that would allow the PMM to determine the adequacy of its provision. The MSSLC placement process, however, was not without some positives. MSSLC continued to place a large number of individuals, individuals were placed from all units at the facility representing all ages and functioning levels, individuals had opportunities to select from different providers and go on overnight visits, and typically, there were multiple PSPA meetings leading up to the final CLDP meeting prior to move. DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related to most integrated setting practices. As this develops, the APC and QA department need to ensure that they are looking at quality of the items on their tool, not just their presence (see Facility Self-Assessment above).

	The post-move monitoring was completed within the required timelines. All of the completed checklists followed the requirements of Appendix C of the Settlement Agreement. Post-move monitoring did not always involve onsite visits and observations at both the day and residential sites. The APC planned for this to happen, given the new state policy and practice expectations. Problems with post move monitoring paralleled those noted in the development of the list of essential and nonessential supports discussed in detail in section T1e. In some of the forms, the PMM indicated serious questions regarding the intent of the PST because of the vague descriptions of supports, and vague or absent descriptions of how to assess presence or absence. Moreover, there was very little narrative in the completed forms. In addition, the specific criterion for each support was not indicated.

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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 continued to engage in many activities to encourage and assist individuals to move to the most integrated setting. These activities 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. Funding did not appear to be an obstacle to any individual's transition. There were no reported instances of a placement being delayed or prevented due to lack of funding and there were reported to be plenty of slots available to individuals at MSSLC. The facility had made some progress in meeting this provision item, however, as noted below, much work still needed to be done in order to achieve substantial compliance. Referral and placement activities continued to be overseen by Alynn Mitchell, the Admissions and Placement Coordinator (APC). She was experienced and very knowledgeable about the court-related processes that affected many of the individuals at MSSLC. She continued to be assisted by Sarah Hewitt, the Post Move Monitor (PMM). In addition, as was planned at the time of the previous onsite review, three additional transition specialists were recently hired to assist with the development of CLDPs and with post move monitoring activities. Two began in November 2010 and the third in mid-December 2010. It was good to see that these positions had been filled and that the transition specialists were beginning their important roles. The number of individuals placed in the community had decreased over the past year. The facility director noted that this was due to the facility implementing a slower and more conservative process in making placements. This was a sensible way to approach	Noncompliance

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		placements, given the complex needs of most of the individuals referred for placement. The specific numbers of individuals who were in the referral and placement process varied from day to day. As a result, there were differences in the numbers presented to the monitoring team in various documents and during various discussions (e.g., see list above in Documents Reviewed). The numbers below are from information given to the monitoring team during the onsite review. • 23 individuals were placed in the community since 9/1/10. This compared with 63 who had been placed at the time of the last review (though those data were for an eight-month period). o The lower number of individuals placed might indicate that more time was taken to find a provider, providers were taking more time to transition individuals and to develop appropriate housing, individuals were being placed who had more challenging needs, or PSTs were taking more time to develop supports to be included in the CLDPs (however, see T1e below). The facility should include this type of analysis as it addresses provision item T1g (see below). • 18 individuals were referred for placement since 9/1/10 and had not yet been placed. This compared with 44 individuals who had been referred at the time of the last review (though those data were also for an eight-month period). o Reasons for the decrease in number of individuals referred might be part of the facility's addressing of provision item T1g. • The total number of individuals on the active referral list was 73 at the time of this review. Many of these had passed the 180-day timeline. o The APC conducted meetings and completed paperwork as required by the state to address the referrals that were older than 180 days. There were many and this might warrant discussion and review by the QAQI Council and perhaps a performance improvement project or corrective action plan. • 168 individuals were described as having requested placement, but were not referred. This compared with 40 individuals at the time of the previous review. o Of these 168 individuals, 10 were not referred solely due to LAR preference. More clarification is needed in future listings because it was unclear to the monitoring team as to whether this was only a listing of individuals who themselves had requested placement, or if it also included all individuals who could not express their own preferences. • 159 individuals were considered alleged offenders. This compared with 162 individuals at the time of the previous onsite review. • The referrals of 21 individuals were rescinded since 9/1/10. o MSSLC had a policy and process to review all rescinded referrals at an	

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		administrative level higher than the PST. This was called the Placement Review Team. Documentation submitted to the monitoring team showed that the Placement Review Team reviewed 13 cases of rescinded referrals. The Placement Review Team also reviewed cases when an individual returned from the community (see below) and cases where the individual or his or her advocate wanted a referral for placement, but the PST did not refer. There were only two of these cases in the documents reviewed, however, as noted above, there were over 100 individuals who requested placement, so it was not clear why only two were reviewed by the Placement Review Team. o In all cases reviewed, the Placement Review Team always agreed with keeping the individual at the facility. All of these decisions appeared to be reasonable, however, as an extra protection for individuals, the facility should consider including these data in its QA program and perhaps keeping DADS central office informed. Overall, however, the monitoring team liked the idea of having this type of Placement Review Team. Other SSLCs might consider something similar, too. There were problems, however, with a number of MSSLC placements over the past year. Although they were a small percentage of the total number of community placements made by the facility, each one should be thoroughly reviewed and studied so that similar problems might be avoided in the future. This is especially important because, given the challenging and complex histories of many of the individuals being placed by MSSLC, a single failed community placement could have a chilling effect on the facility's (and DADS') ability to place individuals (e.g., if there is an injury to an innocent member of the community). • One individual (Individual #294) returned to MSSLC after a failed placement in a community group home. Her placement lasted only a few weeks. She was placed in August 2010, incarcerated in September 2010, and readmitted to MSSLC in October 2010. A review of her CLDP showed that the facility failed to thoroughly and adequately plan for her transition, especially given her history of serious problem behaviors. She carried psychiatric diagnoses that are some of the most difficult to treat: psychosis, personality disorders (antisocial, borderline, ODD), depression, and noncompliance. Yet, there was nothing in her CLDP to address these extremely complicated psychiatric disorders. • Individual #573 moved to the Corpus Christi SSLC catchment area. He moved in with his mother, but shortly thereafter, there were numerous issues regarding her ability to maintain a household (e.g., no stove, moving to another house on the street). Soon thereafter, Individual #573 refused to participate in activities with his home support staff, engaged in major behavioral incidents at public	

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		school, and had an incident at home that resulted in local police intervention. The local police found an outstanding warrant from Mexia/Limestone County and he was placed in jail. The monitoring team met Individual #573 during the previous onsite review. He told the monitoring team that he was so excited about his upcoming move. It was very disheartening to hear how this turned out for him. MSSLC should be doing a thorough review of this case, even though the post move monitoring was being conducted by another SSLC. • Individual #59 moved from MSSLC to a group home in the Abilene SSLC catchment area. The post move monitoring reports from Abilene SSLC indicated that she was having numerous behavioral outbursts, including threats to kill her housemate. Further, in the post move monitoring reports, the community provider reported that staff were never inserviced on her behavior support plan, never received assessments and medical reports, and only later learned about a swallow study. An absence of training and sharing of information, if true, placed this individual at risk for a failed placement. MSSLC should thoroughly review this case, especially regarding the preparation of the provider for the individual's behavioral and psychiatric conditions. • Individual #480's PST had many concerns following his move to a community group home. Many of these concerns were identified by the post move monitor. The PST and PMM were concerned about his weight loss, being fed baby food instead of properly prepared adult food, absence of a motion sensor, and improper and potentially unsafe transportation in the provider's vehicle. These items were identified in his CLDP, however, the provider appeared to be unable to adequately provide these supports. The PST wanted to bring him back to MSSLC and find a more competent provider. Individual #480, however, did not move back to MSSLC and died less than four months after moving to the community. Although his death may or may not have been related to care by the provider, MSSLC should thoroughly review the activities taken to plan his transition and the facility's actions taken during the post move monitoring phase of his placement. According to the UIR, this case was being referred to the Tarrant County DFPS office for possible investigation. The results of that referral were not available to the monitoring team at the time of this onsite review. o The monitoring team believes that the new proposed DADS policy would allow for a PST to return an individual to the facility if the PST felt that serious an action was required to ensure the individual's safety. • Three other individuals who transitioned from MSSLC died less than one year after their placement. All three died since 1/1/11. There was no indication of any problems in the post move monitoring reports; the deaths of all three occurred months after the final post move monitoring visit. Even so, MSSLC	

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		should thoroughly review these cases. Determinations of professionals The APC reported that the facility was addressing the need for ensuring that opinions of professionals were considered regarding referral by engaging in four activities: (a) physicians and psychiatrists were completing assessments to be included in the CLDP, (b) each team member had a separate assessment form to complete for inclusion in the CLDP, (c) a new CLDP document began to be used on 11/1/10, and (d) the APC conducted a training on 2/18/11 on most integrated setting and community living process for staff at MSSLC. These were all good activities that will move the CLDP process forward and may help in properly identifying essential/nonessential supports (see section T1e below). This provision item, however, requires that actions to encourage and assist individuals to move to the most integrated settings are consistent with the determinations of professionals that community placement is appropriate. This is an activity that should occur during the annual PSP meeting. It appeared to the monitoring team that the opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required (this was what was noted in the previous monitoring report). This was based on a review of PSP documents that included little about the opinions of PST professionals. In most PSPs, a statement at the end of the PSP narrative attempted to present the PST's decision regarding most integrated setting and referral. These were typically one or two sentences that provided insufficient detail regarding the opinions of professionals, and led the monitoring team to assume that the professionals did not provide their opinion on this important matter. Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. Examples of what was found in a sample of recent MSSLC PSP documents are presented below. • Individual #497's PST determined that the most integrated setting at the current time was MSSLC. The PSP did not indicate why the PST arrived at this conclusion. • Individual #313's PSP noted that his most integrated setting was MSSLC home L2 until barriers (e.g., aggression) were overcome. His mother agreed, though she stated she would like him return to live at home. This paragraph was more of an explanation of why L2 was an appropriate home for him than it was a description of professionals' determination and opinion regarding referral. • The PSP for Individual #401 noted that his team agreed that "supports should continue to increase positive behavior." The PSP not address professionals' determination or a statement about most integrated setting.	

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		• In the PSP for Individual #53, it was noted that she was a candidate for community placement near her sister in a small home. The MRA, however, was not at the meeting and a referral could not occur until the MRA was present. It was good to see that she was referred, however, the opinions of the professionals on her PST were not identified in the PSP. • For two individuals, the PSP identified reasonable reasons for their continued placement at MSSLC. MSSLC will, however, need to work towards explicitly identifying each professional's opinion in the PSP. The two individuals were Individual #226, due to multiple medical issues, including a tracheotomy; and Individual #548, who was awaiting a risk assessment before the PST would make a referral. • For Individual #6, the PSP stated that the PST "believes the Shamrock Unit where [he] currently resides is the most appropriate setting for [him] at this time. [His] guardians, his parents, wish for him to remain at MSSLC, and the team feels he should remain at MSSLC and continue to make behavioral improvements. • In a number of PSPs, there was no statement at all about the determination of most integrated setting (Individual #383, Individual #441, Individual #356, Individual #251, Individual #342). Perhaps the new style PSP and the upcoming proposed revisions to the DADS policy on most integrated settings practices and the living options discussion will set the occasion for the incorporation of professional's determinations. The facility should ensure that professional determinations are explicitly included in the PSP meeting, and that these professional determinations are clearly indicated in the PSP document. This provision item allows (and calls for) professional determination as separate from both the preference of the LAR and the opinion of the PST as a whole. <u>Preferences of individuals</u> MSSLC worked to honor the preferences of individuals. In one listing, the facility indicated that 168 individuals had requested referral for community placement. This would not be unexpected considering the capabilities and skill level of many of the individuals. PSTs, as observed during the onsite review, appeared to acknowledge this preference and ensure that individuals knew their current status regarding legal issues, behavioral obstacles to referral, and ways to increase the likelihood of being referred. <u>Preferences of LARs and family members</u> MSSLC also attempted to obtain the preferences of LARs and family members and to take these preferences into consideration.	

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		Senior management The APC should develop a regular report for senior management (e.g., weekly, biweekly, and/or monthly). Senior management will be especially interested in the status of individuals on the referral list and, therefore, some narrative information should be included in addition to the numbers. The report should also contain information about the status of individuals who have moved (as noted above) and obstacles to referral, once that information is gathered in a more comprehensive manner. It is likely that this set of information will lead to discussion by senior management at the QAQI Council. Also, these data (i.e., the information in the monthly report) should be incorporated into the facility's QA program.	
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. The state policy regarding most integrated setting practices was numbered 018.1 and was dated 3/31/10. A revised state policy was in draft format. The Monitoring Panel had the opportunity to review this draft revised policy and submitted a set of comments to DADS separately from this report. The new policy contained improvements from the previous version as well as more detail for PSTs. Once finalized and disseminated, MSSLC will need to incorporate these revised policies, practices, and forms into its facility-specific policies. MSSLC had three policies related to placement. One was MSSLC policy on most integrated setting and the community living process, numbers Client Management-12. It had not changed and was not reviewed at this time. A second policy, Placement reviews and appeal (Administrate-21) was updated and a third policy, Placement Review Team (Committees and Councils-39) was new. This latter policy was discussed above in T1a. Implementation of the new state policy and the updating of facility policies to make them in line with the new state policy will lead MSSLC towards compliance with this provision item.	Noncompliance
	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	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 new statewide policies and procedures were being implemented at MSSLC regarding	Noncompliance

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	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.	the PSP process. These policies and procedures were recently taught to the facility's PSP coordinators and the new procedures were put into place in late 2010. Four of the annual PSP meetings held during the week of the onsite review were observed by the monitoring team. At MSSLC, PSP meetings were facilitated by PSP coordinators. There were three at MSSLC and they had full and sole responsibility for facilitating the annual PSP meeting. Each was observed at least once by the monitoring team. Although it was impossible for the PSP coordinator to know details about each individual (their caseloads were approximately 125 individuals), they provided a consistent approach to facilitation of the PSP meeting. In addition to attending PSP meetings, 14 recently completed PSP documents were reviewed (listed above in the Documents Reviewed list). The total sample included individuals representing different levels of referral for placement, need for extensive supports, language abilities, medical needs, and family involvement. <u>Protections, Services, and Supports</u> The revised (but not yet finalized or disseminated) state policy included a more structured way of addressing the living options discussion (LOD) portion of the PSP meeting, both in the meeting and in the written document. Further, it separated the discussion of addressing the individual's preferences (which were derived from the PFW and discussed earlier at the PSP meeting) and the individual's needed supports and services (which were derived from assessments and discussed later at the PSP meeting during the LOD). The revised LOD will help ensure that the PST properly and fully considers an optimistic living vision, considers all aspects of supports and services (to reiterate, preferences will have already been addressed during the earlier discussion based upon the PFW by the time they begin the LOD portion of the meeting). The PSP meetings observed by the monitoring teams were, as designed, free flowing and did not follow the order and format of the written PSP. Although this made sense to do, the written documents did not accurately reflect the breadth (or brevity) of the actual discussions. Although the written PSP needs to follow a structured format, the resulting document needs to reflect the level and intensity of discussion that occurred during the meeting. Of the set of PSPs submitted, Individual #6's appeared to have the most in-depth description of the meeting's discussions. In the PSPs, the descriptions of the type and characteristics of an optimistic environment varied in detail across individuals. The descriptions for Individual #497, Individual #383, and Individual #53 contained more detail than the PSPs for the others in the sample reviewed. Similarly, the PSPs for Individual #356, Individual #383, and	

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		Individual #53 contained more detail regarding needed supports and services than for most of the others in the sample. The monitoring team also looked at the skills chosen by the PSTs to be taught in a formal structured manner using training objectives (called SPOs). Some comments are presented below (also see sections F and S of this report). • Only three of the PSPs reviewed contained an SPO directly relevant to community living. Individual #53 had an SPO to make a purchase and Individual #251 and Individual #548 had SPOs related to job applications. MSSLC should be able to generate community-relevant SPOs for most individuals. • The PSPs of individuals who were referred, or likely to be referred, for placement did not take the opportunity to specifically focus on more intensive skill training of relevant community-related skills (e.g., Individual #249). • The SPOs for some individuals contained only knowledge-based types of SPOs, for example, to be able to provide information about appropriate sexual behavior, STDs, marriage, and drug and substance abuse (e.g., Individual #313, Individual #401, Individual #383). The inadequate list of skill acquisition objectives in MSSLC PSPs begged the question of the adequacy of the facility's skills assessment process in guiding the PST in choosing important objectives for formal (and even for informal) instruction for all individuals at MSSLC. To address this problem, DADS recently convened a statewide workgroup to look at this issue. As of the time of this onsite review, the workgroup had drafted a functional skills assessment that was a revision of the PALS, and was also looking at commercially available functional skills assessments in order to consider whether there might be any that are appropriate for use at the SSLCs. The monitoring team was pleased to learn that these activities were occurring. The QA department and the APC and her staff conducted occasional monitoring of the annual PSP meeting. Monitoring of the PSP meeting can be a very valuable activity that may best be accomplished with the collaborative efforts of the QA department, the APC, and the PSP coordinators. As noted below in T1g, it may be necessary to revise the tool used to monitor the new style of the PSP meetings. <u>Obstacles to Movement</u> There continued to be no coordinated plan or approach to identify and address obstacles to movement to the most integrated setting across the facility (also see T1g below). Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. In most every case, a plan to	

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		address the obstacle was not explicitly being addressed via an action plan as a service objective or training objective. As indicated in T1g below, the state will be requiring the PST to specifically identify obstacles to placement by choosing from 12 different categories. It may be that use of this list will help PSTs at MSSLC to be more successful in identifying and addressing obstacles. Below are examples of obstacles mentioned in the PSP. Only Individual #383's referred to any specific Action Plans. - Individual #53: she doesn't consistently express her preference for moving or staying at MSSLC. - Individual #441: aggression. - Individual #342: aggression. - Individual #6: aggression, other behaviors. - Individual #497: SIB of putting objects in his ears. - Individual #313: (included a long paragraph about his past, including threats to kill his mother) instigates peers, aggression. - Individual #401: (included a long paragraph about behavior history) runs away, impulsive, inappropriate sexual behavior. - Individual #383: inappropriate sexual behavior, instigating peers, not following instructions. - Individual #226: medical concerns. - Individual #251: PST would refer, but MRA not present. - Individual #548: risk assessment needed, updated communication device needed. - Individual #249: legal issues, open arrest for sexual assault. At two of the PSPs observed by the monitoring team, however, there was specific mention of obstacles and a more in depth discussion than reflected in the PSP documents listed above. This may indicate that more discussion is occurring than is noted in the document or than is reflected in any data that were being kept by the facility. At Individual #249's PSP meeting, the PSP Coordinator asked if there were any obstacles that prevented him from being referred. The psychologist spoke up and said that there were certainly conditions that would need to be in place in the community program for him to support a referral. These included (a) there being two male staff on duty at all times, and no female staff at all, and (b) that he was enrolled in appropriate counseling with a licensed sex offender treatment provider. The PSP Coordinator then asked if the PST agreed to do a community referral. No one responded and then psychologist asked the PST members the same question in a different way, that is, whether anyone disagreed, and no one did. At Individual #6's PSP meeting, the psychologist said very clearly that there were two behaviors that were obstacles to her making a referral:	

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		aggression, and calling in false allegations of abuse.	
	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 continued to engage in activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in each of the activities listed in the DADS policy. The facility had begun to address education of individuals and their families on an individual basis. This was demonstrated during the PSP meetings and documented in the written PSP. This was a good start. The next step would be for the PST to specifically report on the activities of the previous year and make a plan for the upcoming year. At this point, the PSPs varied in their description of the individual's activities related to this provision item. Examples are below. • Individual #249 had visited two group homes, an HCS and an ICFMR. • Individual #251 had high awareness of community options and had visited two group homes. • Individual #356 was to be provided opportunities to go on community tours. • Individual #53 had been exposed to community programs in the past. • Individual #497 had gone on two tours. He had not shown a preference. • Individual #401 was to continue to receive informal information (but this was not described), and to continue with training on making informed decisions (but this was not described). • Individual #383 was to continue to receive informal information (but this was not described). He had never visited a group home. • Individual #548 was to meet with the CLOIP worker quarterly. The PSP noted that he wanted to work with horses and cattle someday. • Individual #313 and his mother were to receive information about community options. She stated that she was not aware of options. • Individual #441 lived on a locked unit. At the time of his PSP, the PST reported that community education was not a priority for him. • Individual #226 was not referred due to serious medical issues and, therefore, the PST did not make plans for him to receive education on community options. • Individual #342's PSP did not note any educational activities related to community options. The annual provider fair had occurred prior the previous onsite review and was discussed in the previous report. It was scheduled to occur again in June 2011. The APC gathered data from the past three provider fairs. The number of individuals and staff who attended remained stable. The number of providers dropped off in 2010, but the APC reported that there was terrible weather that day, including many flooded roads,	Noncompliance

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		and as a result many providers cancelled. No family members attended for the past two years. The data for the past three years 2008, 2009, 2010 were, respectively: • Individuals: 121, 102, 90 • Staff: 109, 115, 119 • Family/LAR: 5, 0, 0 • Providers: 33, 44, 17 The monitoring team continues to encourage the facility 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. Making the provider fair as effective as possible is of interest to all of the SSLCs. For example, during the statewide conference call on Thursday 3/17/11, the provider fair was one of the topics and the group agreed to share best practices. The APC engaged in a number of training activities. One was a training for PST members regarding the CLDP and community living processes. Local MRA and provider staff participated. More than 100 MSSLC staff attended. Another was a session for the family association. The APC and her staff presented information on alternate living. She reported that the presentation was well received. About 40 family members attended (many more than attended the provider fair). Many administrative and management staff attended the session, too. A third session was regarding most integrated setting practices and the APC conducted a questionnaire following the training. The results were not yet tabulated. A Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) continued to be 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 CLOIP process had been in place for a number of years. The monitoring team, therefore, recommends that the facility assess the effectiveness of the CLOIP process, that is, whether or not it achieved the outcomes the facility intended it to achieve. The online family survey can also provide information for the facility regarding family/LAR knowledge and satisfaction with the information they've received. The survey is new and there were only a handful of respondents at this time. One respondent, however, noted that she was rarely informed of referral information (see question #32). The facility took individuals on visits to community providers. The facility had made progress in organizing its system of planning, documenting, and reporting. Many more individuals and facility staff visited community providers than during the time of the previous onsite review. The facility reported that 46 individuals had gone on tours since	

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		the previous onsite review, compared with 16 who had gone on tours during the six months prior to the previous onsite review. The APC reported that the CLOIP staff maintained a list of all individuals at the facility and tried to give everyone at least one opportunity each year. The process was for the CLOIP worker to contact the residential unit director to set up the tour. They APC next planned to compare those who had participated in tours to those who had not, and to look at their CLOIP worksheets and notes. The monitoring team recommends that these activities also be tied in to the description of the individual's education plan that is described in the PSP. Notes were written for each tour. The comments were brief, but gave an adequate indication of who participated, where they visited, and each individual's response and reaction. This information should be summarized in some way, so that the CLOIP worker and APC can have a facility-wide way of tracking and planning for future tours. The APC should incorporate data on tours into the admission and placement department's data, and include these data in the facility's overall QA data system, such as number of individuals who have gone on tours, number of providers visited, number of direct care staff who have gone on tour, and so forth (see section E above). Finally, although not solely related to education about community placements and providers, the self-advocacy activities at MSSLC provided an opportunity for another venue to educate individuals about community placement and the community placement process.	
	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	This provision item required the facility to assess individuals for placement. The facility reported that the living options discussion of the annual PSP was the way this was accomplished. The monitoring team understands the difficulty in determining a process for assessing an individual for placement, that is, what tools, questions, or criteria, if any, should be included. Therefore, as noted in the previous monitoring report, the facility will need guidance from DADS regarding this provision item. Consequently, it is rated as being in noncompliance. If the position of the facility is that the PST goes into the annual meeting with the concept that all individuals can be supported in the community (with very few exceptions), the PSP meeting and PSP document will need to clearly show discussion of the supports the individual needs wherever he or she will be living, obstacles to community placement,	Noncompliance

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	policies, procedures, and practices.	and methods to address these with action plans. It is possible that a combination of a document review (of PSP) and an observation review (of PST meetings) could show that the facility did an assessment of the individual for placement. Further, the PSP might include an explicit statement, such as "The PST assessed (the individual) for placement by doing the following:"	
T1c	When the IDT identifies a more 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:	As noted in section T1b above, the DADS policy on most integrated setting practices was being revised. This included development of a new CLDP document format, and the process for managing the CLDP. Recent training had been conducted by the DADS central office continuity of care coordinator on the new CLDP. The monitoring team had the opportunity to review this new CLDP form a few months ago. These comments were presented in previous monitoring reports for other SSLCs. DADS has taken these comments into consideration and, therefore, the comments are not repeated here.	Noncompliance
	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 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. As noted above, this policy, including the CLDP process, was being revised. The monitoring team reviewed 14 of the most recently completed CLDPs (listed above under Documents Reviewed). At MSSLC, the new CLDP was being used for all referrals that occurred after 11/1/10. Therefore, none of the CLDPs reviewed by the monitoring team were under the new format. 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. The 14 CLDPs were surprising similar, if not identical, in many aspects. The lack of individualization, especially in the listing of essential and nonessential supports was problematic and is described in more detail in T1a above and T1e below.	Noncompliance

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		During the time of the previous onsite review, DADS central office was providing written reviews of each CLDP. That process was no longer in place at MSSLC (in part due to the facility receiving some onsite support from central office), but should be re-instated. It was helpful to MSSLC and the APC and her staff would benefit from having their CLDPs reviewed. Of note, however, was that MSSLC was beginning to implement an important aspect of the new CLDP process. Specifically, that the CLDP process constituted of a series of activities and meetings, and that activities around placement were beginning prior to the CLDP meeting, which had typically been held only two or three weeks prior to the individual's move to the community.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDP clearly indicated the staff responsible for certain actions and activities.	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.	The CLDP contained evidence of individual review. This was also evident during observations of PSP and CLDP meetings.	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.	In preparation for the CLDP meeting, assessments were to be updated and summarized. Therefore, the CLDP document was to contain these updated/summarized assessments, rather than full assessments. This appeared to be an adequate process. These assessment updates were included with 13 of the 14 CLDPs reviewed by the monitoring team. In addition, the APC continued to keep a checklist of all required assessments. Seven of these were reviewed and indicated that this was a typical part of the APC's CLDP management activities. The APC reported that she reviewed all assessments and all assessment updates/summaries in order to ensure that all recommendations were reviewed and considered by the PST during the CLDP meeting. The outcome of this, however, as indicated below in T1e, was inadequate because many important supports did not make it to the list of essential/nonessential supports for most individuals.	Substantial Compliance
T1e	Each Facility shall verify, through	This provision item requires the identification of a set of individualized important	Noncompliance

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	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.	supports that the PST determines are critical for the individual's success in his or her new placement. These are labeled as either essential supports (those that must be in place prior to the individual's move) or nonessential supports (those that must be put in place, but aren't required to be in place on the day of the move). The development of these lists of supports is one of the most important aspects of planning for each individual's move. The creation of the list of essential and nonessential supports provides the PST with the opportunity to ensure that the new provider provides the individual with all of the aspects of service and support that the PST deems necessary. PST members should never lose sight of their responsibility and opportunity, that is, that this is their chance to ensure that the individual gets what he or she needs and wants. Many PST members have, for many years, cared for, and cared deeply about, the individuals who are transitioning. They should not squander this opportunity to increase the likelihood of their individual's success at his or her new home. Unfortunately, the lists of supports in the CLDPs were inadequate and indicated serious problems in the planning of this aspect of each individual's transition. Problems in identifying essential and nonessential supports were identified in the baseline monitoring report and again the previous monitoring report. In the baseline report, numerous examples were provided by the monitoring team. In the previous monitoring report, the monitoring team detailed problems in one individual's transition. Further, at the time of the previous onsite review, DADS was conducting a written review of each MSSLC CLDP. These reviews had not been conducted in many months and should be reinstated. As a result of the previous monitoring reviews, the APC engaged in some activities towards improving the facility's performance in this area: • The APC developed a tracking sheet showing the date of referral, whether or not a transition specialist was in attendance, and a follow-up meeting if the transition specialist was not in attendance at the meeting during which a referral occurred. The intention was that the discussion of identifying essential and nonessential supports could begin right then, that is, months before the final CLDP meeting that occurs only a few weeks prior to placement. Eleven individuals were listed on this sheet. • The APC developed another table showing whether the CLDP indicated that supports were to be verified (from 17 recent CLDPs). This, however, was merely a list indicating if evidence was in the CLDP, not whether the evidence was observable and measureable.	

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		These activities, however, failed to address the underlying problem with MSSLC CLDPs, that is, the need for the proper and thorough creation of a detailed and individualized list of essential and nonessential supports for each individual. The MSSLC APC and her staff would benefit from, and should receive, support and training from DADS central office regarding the development of appropriate and individualized lists of supports. The monitoring team expects that the APC and her staff would welcome this support. There are three components to a proper list of essential and nonessential supports. • First, the CLDP needs to include supports from a wide range of possible supports. This should come from the o individual's personal preferences and interests, o family members and LARs, o written assessments and updates from PST members, o other documents, such as the PSP and PSPAs, and o discussion at PST meetings. • Second, supports, both essential and nonessential, need to be described in adequate detail, using observable, measureable, and verifiable terminology. The wording must provide the facility, the receiving provider, and the post move monitor with adequate guidance regarding the provision and monitoring of each support. • Third, the way in which provision of the support is to be verified must be provided. The CLDP needs to specify what should be observed by the post move monitor (e.g., paperwork, items, interactions with staff) and at what criterion (e.g., twice per week). The monitoring team reviewed 14 CLDPs. Below are general comments regarding the set of CLDPs. • Almost every individual had only two or three essential supports and they were almost identical in every case: 24 hour awake staff, vehicle for transportation, and shower chair. • Most of the nonessential supports referred to the provider staff receiving training on aspects of the individual's care (e.g., PBSP, PNMP), but failed to list the important components as separate supports in the CLDP. As a result, the PMM only checked for whether inservice training occurred, not for whether the service or support was adequately provided. • The required evidence did not include detail that would allow the PMM to determine the adequacy of its provision. Many described the evidence as "documentation," "inservice sheets," or "MSSLC documentation." Below are comments regarding many of the individual CLDPs.	

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		Individual #180 (this was the most recently completed CLDP): • Nothing in the CLDP addressed her history of three previous failed placements. Even though the last failed placement was 10 years ago, there was no mention of this and no direction given to the provider. • She had a diagnosed personality disorder and some of her current behavioral presentations reflected that this was still present, although at low rates. Again, considering that her last failed placement resulted in a 10 year wait until she again had the opportunity for placement, a support for addressing her psychiatric needs was surprisingly absent. • A job appeared to be important to her, however, there were no supports listed for her to earn money or to have a job. • She had a risk of falling, but there was no support listed to address this risk, other than a reference to an inservice on adaptive equipment. • Weight and diet were important factors in her health. An inservice on nutrition was the only related support listed. • There was no support for monitoring for tardive dyskinesia. • There was no support for maintaining family contact • There was nothing about continuing with her training and skill development, including self-administration of medication. Individual #467: • The OTPT assessment listed 21 important items, however, none were included in the list of supports. These included having the head of her bed elevated, providing multiple opportunities each day for her to walk through the group home with staff assistance, and changes in her wheelchair position every 60 minutes. Merely stating that the provider staff will receive an inservice is a woefully insufficient way to ensure that these supports are being provided. • She had GERD and dysphagia (two potentially serious conditions), however, they were not addressed in the list of supports. • She had specific activities that she preferred, including going to McDonalds and Dairy Queen for ice cream. These should have been included, but weren't. • Similarly, she liked to use a recliner, but this wasn't included as a support. • It was good to see that they did have a support for her to have her communication device, however, the evidence required was nothing more than signed inservice sheets. • She had a support to have pureed food textures, but the only evidence required was that there was a menu at the home. Individual #298: • A job was very important to him and he especially liked cars, however, there were no supports other than for him to attend "Goodwill day programming."	

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		• He liked to be active, but there were no supports about that. • There was a support for staff to receive an inservice on his BSP and that staff would provide supervision, but a signature on a staff inservice sheet was insufficient, especially given his history of running away. • He had been learning a number of skills at MSSLC. None were included in the list of supports: reading, math, money management, self-administration of medication, traffic safety, or getting a drivers license. • There was no support for monitoring for tardive dyskinesia. Individual #166: • He had a history of serious problem behaviors, including aggression, suicidal behaviors, assault on a police officer, and inappropriate sexual behaviors. He was reported to have "impulsive outbursts" and to be "unpredictable." The CLDP indicated that his behavior had been stable for the previous seven months. Given his history, that was an extremely short period of time. • There was nothing about him receiving group counseling, though this was noted as a need in his assessment update. • Similarly, there was nothing about transitional counseling, which was also specifically mentioned in his assessment update. • A job seemed to be critical to his success in the community, however, the only support listed was a referral to DARS. • Apparently he had a history of refusing medical and nursing services. This was not addressed. • He was overweight, but the only support on the list was for him to have a "healthful diet" with evidence being presence of a weight chart. Individual #509: • There was no support for monitoring for tardive dyskinesia. • There was no support to continue his goal of improving his reading and writing. • Getting a job in food service and earning money were listed as important to him. His only support listed was to attend day programming. • He loved NASCAR and wanted to have leisure activities around car racing. None of this was listed. • Monthly weights seemed to be an important topic at his CLDP meeting, but was not on the list of supports. Individual #111: • There were no supports for her need for ground food textures and food supplements. • There were no supports to address her risk of injury from falls and her need for a gait belt and assistance when walking. Individual #408: • There was a support for him to "continue daily living skills," but the evidence	

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		was a poorly defined phrase "training objectives." • He had a support "modified diet," but there was no specific mention of his need for pureed food and his risk of choking. Individual #450: • There was nothing about her very favorite things: dolls, drawing, and favorite foods. • There was nothing about her need for a ground diet. • There was nothing about her need for gait belt, and for her wheelchair to be at a tilt. Merely listing a staff inservice is insufficient. Individual #292: • Some training objectives were included; this was good to see. • The OTPT supports were directly copied from the assessment without any regard to whether or not the wording made sense. As a result, the CLDP included the supports, "eats independently" and "walks independently." • There was nothing about getting a job. Individual #240: • It was good to see that he had a support for counseling, however, it was written as a nonessential support. Instead, it should have been an essential support, given that the psychologist's assessment update noted that it should be provided "as soon as possible," a phrase rarely seen in a CLDP. • It was also good to see that he had a support related to his work skills. Individual #294: • See comments above in section T1a. Individual #232: • The monitoring team attended his CLDP meeting and participated, somewhat, in the discussion of choosing supports and in describing evidence. As a result, one of his supports had more defined evidence (e.g., four times per month, documented in notes). • During his meeting, important aspects of his support were raised by the monitoring team (e.g., attention deficit disorder issues, his preference for riding his bicycle, his preference for having a job). The MSSLC placement process, however, was not without some positives. First, MSSLC continued to place a large number of individuals, and placement was a desired outcome for many individuals at the facility. Second, individuals were placed from all units at the facility, representing all ages and functioning levels. Third, individuals had opportunities to select from different providers, visit different homes, and go on overnight visits. Fourth, for many individuals, there were multiple PSPA meetings leading up to their final CLDP prior to move. Fifth, the CLDPs contained a good description of the individual's history of placement and activities that led to this placement. These were all important	

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		and positive characteristics of the MSSLC placement process.	
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.	MSSLC had made progress in this area. DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related to most integrated setting practices. These reviewed the living options discussion at the annual PSP meeting, the CLDP document, and the post move monitoring documents. The APC was implementing all three of these tools. Specifically, she conducted three reviews per month, two for individuals who had been placed, and one for an individual who had not been referred. In addition, QA department staff conducted occasional interobserver agreement checks. It was great to see that they were starting on this process and that it had become regular and typical part of the APC work week. As this develops, the APC and QA department need to ensure that they are looking at quality of the items on their tool, not just their presence. Further, they will need to ensure that the contents of their tool, and the definitions they use to determine presence are consistent with that of the soon-to-be-disseminated revised state policy and with that of the monitoring team. For instance, the facility's completed tools answered "Yes" to the item regarding the determination/opinion of professionals regarding referral and placement. Based upon the comments above in section T1a, the monitoring team would have scored this item as not being present. Similarly, the tools may need to be revised to get at the depth of quality required for properly identified and managed essential and nonessential supports (see T1e above), and to correctly capture the important aspects of the living options discussion at the PSP meeting (rather than only what's in the written PSP document). In addition to the implementation of self-monitoring, data from the referral and placement activities at MSSLC should be submitted to and incorporated into the QA program at the facility (see section E above). Certainly, a variety of data can be collected and reported by the APC that would be of interest to the facility's QA department and to its senior management team. Examples include: • Individuals placed • Individuals referred • Obstacles to placement • Action plans related to obstacles • Educational activities • Number of providers, quality of providers	Noncompliance

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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 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.	At the facility level, MSSLC was not in compliance with this provision item. MSSLC was gathering some, but not all, relevant information regarding obstacles across the facility. MSSLC was not analyzing information related to identified obstacles to individuals' movement to more integrated settings. Further, as indicated in this provision item, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. The data presented to the monitoring team were for 94 individuals. Only one obstacle was listed, even if there was more than one obstacle. The data indicated the following obstacles to placement: • LAR preference 12% • Behavior/psychiatric 61% • Medical 1% • Citizenship 3% • Only wants to live with family 1% • MRA not present 9% • Legal issues 16% • Pending community risk assessment 7% At the state level, at the time of the onsite monitoring visit and subsequent preparation of this report, DADS developed an initial report designed to ultimately meet the requirements of this provision item. The statewide report provided an overview of how obstacles were to be identified, a definition of each of 12 different categories of obstacles, and a description of 11 steps the state and facility might take to address some of these obstacles. As discussed with DADS management, the goal was for the state to gather all of the data on the 12 categories of obstacles and create a statewide plan. In addition, the statewide report would include • an appendix for each of the SSLC that provided data specific to that facility, • additional information specific to that facility, such as related to location, population, staffing , and • steps to overcome that facility's specific obstacles. Some obstacles might be able to be resolved at the facility-level, while others will need state intervention. The data that will be used were being entered into the system as each individual planning session transpired. This was to occur beginning 9/1/10, however, no data were submitted to the monitoring team. If implemented, this appeared to be a reasonable approach to reaching substantial compliance with the requirements of this provision item.	Noncompliance

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		The monitoring team recommends that further information be collected regarding one type of obstacle, that is, LAR preference for the individual to remain at the SSLC. Rather than solely listing this as an obstacle, the report should indicate the reasons for the LAR's preference (i.e., reluctance to support referral). This information will be helpful to DADS and to each facility.	
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, 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.	The monitoring team was given a document titled "Community Placement Report." It was updated 3/15/11 (i.e., during the week of the onsite review). This provision item was found to be in substantial compliance given the current contents as well as the facility and state's intention to include, in future Community Placement Reports, a list of those individuals who would be referred by the PST except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T1a, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The state indicated that at this time, its data system did not include this information, but it was working toward being able to produce these data in the near future.	Substantial Compliance
T2	**Serving Persons Who Have**		

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	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. Post move monitoring was conducted by the post move monitor, the three transition specialists, and the APC. A recent change in state policy and practice required each SSLC to post move monitor all of its own placements. MSSLC placed individuals all over the state and, therefore, was now traveling to conduct these post move monitoring visits. Although the scheduling and traveling that was required made this challenging, it will ultimately be beneficial to the placement process because the staff doing the post move monitoring will be familiar and knowledgeable about each individual, especially given the complicated needs of many of the individuals placed by MSSLC. This was not the case when post move monitors from other facilities were doing the post move monitoring. This was a good change in process for DADS and the SSLCs to have made. MSSLC maintained a list to track all of their required post move monitoring activities. A set of completed post move monitoring forms was submitted to the monitoring team. The sample submitted, however, contained completed post move monitoring forms for only seven individuals. Forty-five-day post monitoring was submitted for only two of these seven, and 90-day post move monitoring was submitted for only one of these seven. MSSLC should be sure to submit a representative sample of PMM forms for the next onsite monitoring review. The post-move monitoring was completed within the required timelines. All of the completed checklists followed the requirements of Appendix C of the Settlement Agreement. Post-move monitoring did not always involve onsite visits and observations at both the day and residential sites. The APC planned for this to happen, given the new state policy and practice expectations. A new form was being used for post move monitoring. Three issues with the new PMM form are briefly presented below. Additional details were shared with DADS central office staff during the onsite review. • The new format had only a narrow column on the right side for comments. The monitoring team recommends that the form be revised to include a larger space for comments. • The previous form had a column for the PMM to indicate yes/no/na for each support. The new form did not contain this column, but should. • The inclusion of a column to indicate the evidence that the PST determined	Noncompliance

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		would be required to be present to indicate presence of the support was an excellent and needed addition to the post move monitoring process. Making this type of determination should not be the PMM's responsibility; instead it should be done by the PST, most preferably, during the CLDP meeting. Thus, the PST, at the CLDP meeting, needs to identify, for every essential and nonessential support: o what evidence should be present, and o the criterion for this evidence. Problems with post move monitoring parallel those noted above in the development of the list of essential and nonessential supports discussed in detail above in section T1e. In some of the forms, the PMM indicated serious questions regarding the intent of the PST because of the vague descriptions of supports, and vague or absent descriptions of how to assess presence or absence. Moreover, there was very little narrative in the completed forms. In addition, the specific criterion for each support was not indicated. Below are comments from the set of submitted post move monitoring forms illustrating these problems. Individual #584: • In the 7-day review form, there were multiple notes written by the PMM that she and/or the provider were not clear as to what the PST was referring to regarding numerous supports (i.e., the wording was not clear). As a result, she was unable to assess these supports. The PMM (and the community provider) should not leave the CLDP meeting until they understand what it is they are supposed to be providing (the provider) or looking for (the PMM). o In these cases, however, there was follow-up. There were PSPA meetings during which the PMM's questions were addressed and answered. • In the 45-day review form, there continued to be questions for the PST regarding a number of the supports. • There was no direction to assess evidence for the communication dictionary, however, it was scored as being in place (i.e., a Yes score). • The evidence for the support "training is occurring" was "training objectives." This was not adequately described, for example, the specific training topics, frequency of implementation, and type of documentation were not described and, therefore, left for the PMM to determine. Individual #83: • All of her essential supports were recorded as being in place, but there was no indication as to what was looked at by the PMM. • For the support "participate in activities she enjoys," the PMM wrote, "has been	

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		to the mall for a fun fair." Although this was likely an appropriate activity, there was no criterion to indicate the expected minimum frequency and variety of activities required. • Staff were found to not have received training in all areas, but the PMM noted that this was not unexpected. The facility and PMM should fully expect that staff have received the required trainings before the individual moves to his or her new home. Individual #277: • The new PMM form did not have a place for the PMM to record whether the support was or was not in place (i.e., a yes/no column). • There was no criterion for support item1B. Individual #81: • His 7-day post move monitoring occurred in both settings; this was good to see. • The problem with lack of specificity in the description of the support and its associated verification led to discussion at one of his post move PST meetings at MSSLC. The MSSLC nutritionist wanted assurance that he received chocolate milk and his dietary supplement. The PMM notes indicated that these items were observed at the home, but the nutritionist wanted assurance. The community provider's response was that MSSLC "can be assured he is receiving his nutritional supplement as well as the chocolate milk." The monitoring team agrees with the nutritionist, that is, that for this very important support, more evidence is needed than a verbal assurance from the provider. 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. Yet the case of Individual #480 demonstrated the facility's frustration with being unable to ensure that the community provider followed through on its agreement to provide the agreed upon supports. Please see the more detailed description above in section T1a. MSSLC had recently begun holding a PST meeting after each PMM checklist was completed. This was an excellent idea and may help support the success of individual's placements, especially if problems have arisen and/or if supports are not being provided. At the statewide level, the DADS Central Office Continuity of Services Coordinator held a monthly conference call for the APCs from all of the facilities. The monitoring team had the opportunity to attend this call during the week of the onsite review. The monitoring team continued to be impressed with the Continuity of Services Coordinator's commitment to achieving substantial compliance with all of the provision items of section T of the Settlement Agreement. The topics of the conference were relevant to	

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		most integrated setting practices and included provider fairs, post move monitoring, community placement data, central office reviews of CLDP drafts, the upcoming addition of a more structured living options discussion in the PSP meeting and document, and an upcoming two day meeting for all APCs and PMMs in Austin.	
T2b	The Monitor may review the 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.	As noted above in section T2a, post-move monitoring visits were occurring at MSSLC. The monitoring team had the opportunity to accompany the post-move monitor on a visit to the group home of Individual #41 for his 90-day post move monitoring visit. It was conducted by the APC (the PMM was not available on this day). The purpose of this visit was to learn about the post-move monitoring process, see the community home, meet the individual, learn about transition and services, and see the status of some of the essential and nonessential supports. The monitoring team wishes to thank the APC and the community agency for making arrangements for this visit to occur. The provider was Ruth Marie's Country Homes. This was the second time the monitoring team toured a home of this provider. This home, as was the case with the other home, appeared to be a good place to live and one in which good care was provided. The owner of the company, his assistant, and a direct care staff were present. The APC used the PMM form and went through each support one by one. As was not surprising (given the problems noted above), most of the supports were not defined in a way that clearly indicated how the APC was to determine its presence. The monitoring team took the opportunity to explain ways in which each support could have been defined more adequately and the types of evidence a PMM could, and should, ask to see. Examples included comparing the staff schedule to staff sign in sheets, seeing if the fence in the yard was safe and secure, making sure the blender and food processor were in working condition, and ensuring he had pancakes regularly (one of his favorite foods and one that was listed as a support). Although some of these may appear to be relatively minor supports, better definition will be especially important for individuals who have more complicated support needs (this individual did not have complicated support needs, such as psychiatric, behavioral, or medical concerns). As stated in the previous report and repeated here, 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.	Noncompliance
T3	**Alleged Offenders -** The provisions of this Section T do not	This item does not receive a rating.	

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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	Three individuals were discharged properly as per the requirements of this provision item as evidence by documents submitted to the monitoring team. The individuals and the reasons for their discharge are below: • Individual #566: found competent, discharged due to time served. • Individual #348: LAR decision to move him to a nursing home. • Individual #551: returned to court, found competent to proceed.	Substantial Compliance

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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.		

Recommendations:

1. Implement updated DADS policy on most integrated setting practices, when it is disseminated.
2. Implement the updated version of the living options discussion as per the updated DADS policy.
3. Revise facility policies to be in line with the updated DADS policy.
4. Ensure that the opinions of professionals regarding referral are obtained and explicitly documented, separate from the preferences of the LAR and the team as a whole.
5. Identify and address the obstacles to each individual's movement to the most integrated setting within the PSP for each individual.
6. The PSP document should also:
    a. reflect the level of intensity of discussion that occurred at the meeting,
    b. include an explicit statement regarding how the individual was assessed for placement.
7. Ensure that relevant information is submitted and monitored by the QA department and regularly submitted to senior management for review.
8. Implement a plan (e.g., performance improvement project, corrective action plan) to address referrals that are older than 180 days.
9. Review all failed placements, problematic placements, and placements of individuals who died after recently transitioning to the community.
10. Create a correct and thorough lists of individuals who would be referred except for the preference of the individual's LAR. This list should be for individuals who can, as well as those who cannot, express a preference.
11. Ensure that training objectives are related to community living and to any identified obstacles. For those individuals who are referred, a larger set of training objectives should be considered.
12. Identify and address obstacles to referral and placement across all individuals at the facility by conducting a comprehensive assessment and analyzing the information as required by provision item T1g. Include a review and analysis of the fluctuating numbers of placements and referrals.

13. Identify, for each individual, the plan for the upcoming year to educate the individual and his or her LAR regarding community options. Include a description of what was conducted over the previous year. This could be included in the PSP document.

14. Determine desired outcomes and assess the effectiveness of educational activities, including the provider fairs, the CLOIP process, and community tours.

15. Improve the way important essential and nonessential supports are included in the CLDP:
    a. Ensure that a wide range of all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
    b. Define each support in observable and measureable terms, and define the manner in which the presence of each support will be verified.
    c. Include a criterion along with the evidence required for each support.

16. Consider revising the post move monitoring form as per the comments in T2a.

The following are offered as additional suggestions to the facility:

17. DADS should continue to provide feedback and suggestions on the facility's CLDPs to the APC. In addition, 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 eventually being necessary.

18. Update the facility's tool for monitoring the PSP meeting so that it is in line with the new style PSP meeting and so that it contains monitoring of the discussion of the most integrated setting/optimistic living vision.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o List of individuals for whom an LAR had been obtained since 9/1/10 o DRAFT DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Personal Support Plans for: • Individual #497, Individual #72, Individual #40, Individual #53, Individual #261, Individual #441, Individual #228, Individual #401, Individual #382, Individual #113, Individual #132, Individual #313, Individual #360, Individual #514, Individual #175, Individual #259, Individual #159, Individual #342, Individual #548, Individual #226, and Individual #251. Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs; o Lloydette Harris, Human Rights Officer o Valerie McGuire, QMRP Director Observations Conducted: o Observations at residences and day programs o Daily Incident Management Review Team Meeting 3/14/11 and 3/15/11 o Behavioral Therapy Committee Meeting 3/14/11 o Restraint Reduction Committee Meeting 3/16/11 o Human Rights Committee Meeting 3/15/11 o Shamrock Unit Meeting 3/15/11 o Quarterly PST meeting for Individual #225 o Annual PSP meetings for Individual #374 and Individual #413
	Facility Self-Assessment: The facility's POI indicated that the facility had assigned a rating of noncompliance to both items in this provision and were waiting on the new state policy to address consent and guardianship issues. The monitoring team agreed with the finding of noncompliance for this provision.
	Summary of Monitor's Assessment: Since MSSLC did not indicate it was in compliance with any of the provisions of this section, and particularly, since it indicated it was waiting on the final statewide policy and training before taking most actions, the monitoring team reviewed a small sample of documents in order to be able to assess progress,

	if any, from the previous review and provide any additional recommendations that may be helpful to the facility when it does undertake action in these provisions. Comments are as follows: • Provision item U1 was determined to be in noncompliance. The facility did not maintain a prioritized list of individuals needing an LAR. Not all PSTs were adequately addressing the need for an LAR or advocate. • Provision item U2 was determined to be in noncompliance. The facility was not actively pursuing guardianship for individuals at MSSLC. Compliance with this provision item will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite.

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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.	MSSLC did not have a policy in place for developing and maintaining 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. The state developed a draft policy to address this provision, but had not yet released it to the SSLCs for implementation. The facility's POI indicated that it plans to take action in these areas once the policy was finalized. The facility had a new rights officer. This staff member will have the responsibility to develop a process to meet compliance with provisions described in Section U. At the time of the monitoring visit, the facility had begun to establish a list of individuals with need for an LAR or advocate. There were eight individuals identified as in need of a guardian and four individuals identified as in need of an advocate. The list was not prioritized. In 20 PSPs reviewed, there were eight individuals (40%) who did not have guardians. There was at least minimal discussion of the individualized need for an LAR in seven (88%) of the eight PSPs for individuals who did not have guardians. Only one (Individual #548) had been referred for a guardian. Examples included: • Individual #514 did not have an LAR. Her PSP indicated that the team determined that her father served as her advocate, so she did not need a guardian. Her PSP did not include a discussion regarding her ability to give informed consent. The Human Rights Committee had restricted her access to money, phone calls, and tobacco use. • Individual #251 did not have a guardian or advocate. The PSP indicated that a request for an advocate had been previously made and the QMRP would follow-up on this. • Individual #226's PSP indicated that he did not have a LAR, but his sister served as an advocate for him. The PSP documented that his sister had been given	Noncompliance

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		information on guardianship, but did not wish to pursue becoming his guardian. There was no discussion regarding his ability to give informed consent in the PSP. His rights assessment indicated that he was unable to give informed consent in making medical decisions, programmatic decisions, and financial decisions. A referral had not been made for guardianship. • Individual #548 did not have an LAR or an advocate. His team had made a referral for guardianship. • Individual #342 did not have an LAR or an active advocate. There was no discussion regarding the need for a guardian or his ability to give informed consent. • Individual #356 did not have an LAR. His family did stay in contact with him. His PSP indicated that his uncle was looking into guardianship. There was no discussion regarding his ability to give informed consent. • Individual #159 did not have an LAR. His PSP indicated that his mother served as his advocate. His PSP did not indicate that the team had discussed his need for guardianship or his ability to give informed consent. • Individual #259 did not have an LAR. His PSP indicated that his aunt and uncle served as advocates for him. There was no further discussion regarding the need for a guardian or his ability to give informed consent. • Individual #175 did not have a guardian. Her PSP indicated that siblings advocated on her behalf and that they had been given guardianship information. Her PSP did not indicate that the team had discussed her ability to give informed consent. There is concern that the facility was routinely restricting basic rights of individuals living at MSSLC with no discussion regarding the individual's ability to give informed consent or determination of the need for an LAR.	
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	MSSLC did not have policy or procedure established to implement this provision item. It reported it was awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before developing facility-specific documents. According to documentation provided to the monitoring team, there was one individual at the facility who had obtained a guardian since 8/1/10. The facility did have some rights protections in place including an assistant ombudsman housed at the facility and a rights officer employed by the facility. There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of	Noncompliance

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	primary correspondent for 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.	rights for individuals at MSSLC. The HRC, chaired by the rights officer, included a parent representative, and facility staff from various disciplines. The monitoring team observed the HRC meeting held the week of the monitoring visit. The committee, unfortunately, did not effectively review and discuss rights restrictions. Only very basic information was presented to the committee and restrictions were approved with little appropriate discussion. There was also a self-advocacy group on campus. The monitoring team attended the self-advocacy meeting held the week of the monitoring visit. The group was led by the rights officer and encouraged individuals to begin advocating for themselves. The group was struggling with attendance and a focus. See sections E and T of this report for more discussion around self-advocacy. The facility had just begun having smaller house meetings that were structured to give individuals an opportunity to voice their opinions and concerns regarding facility processes. This was a positive step towards self-advocacy. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals.	

Recommendations:

1. Develop a prioritized list of individuals in need of an LAR.
2. Develop a list of LAR providers in the area.
3. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR.
4. Continue to provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming an LAR.
5. 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.
6. Continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals.

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7. Improve the operation of the HRC so that it meets the intent for which it was designed.

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 Organizational chart, 2/15/11 o MSSLC policy, Recordkeeping Practices, Administrative Services-6, dated 3/10/11 o MSSLC policy lists, 2/17/11 o List of typical meetings that occurred at MSSLC o MSSLC POI, 2/24/11 o MSSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/14/11 o Table of contents for the active record and the individual notebook o New state-provided tables of contents active records and individual notebooks, to be put into effect in April 2011 o Table of contents for the master record, dated 7/5/10 o List of all staff responsible for management of unified records o Two spreadsheets that tracked the status of state and facility policies for each provision of the Settlement Agreement o Checklist used by the PSP Coordinators to indicate which documents are completed and which still need to be obtained: blank form and three completed samples o For November 2010, December 2010, January 2011, and February 2011, completed: o audits of active records (10 each month), o list of items that needed to be corrected, and o follow-up tracking as to whether these items were corrected o Two completed active record reviews done by home record clerks o Audit reviews initiated by Debbi Reichert, home record clerk, Whiterock Unit, and follow-up documentation completed by the URCs o Email regarding individual notebooks from Becky McPherson to the SSLCs, 12/9/10 o State draft questionnaire on use of records (for V4) o Two completed staff surveys regarding use of records o Active records of many individuals who lived at MSSLC during observations in residences o Review of active records and/or individual notebooks of: • Individual #481, Individual #178, Individual #232, Individual #335, Individual #283, Individual #249, Individual #6 Interviews and Meetings Held: o Elaine Schulte, Director of Client Records

	o Sherrie Price and Misty Samuels, Unified Records Coordinators o Etta Jenkins, Settlement Agreement Coordinator o Brenda Shoemake, Assistant Director of Programs o Barbara Shamblin, Bertha Allen, John Parks, Troy Miller, Polly Bumpers, Residential Unit Directors o Numerous staff and clinicians during observations in residences <u>Observations Conducted</u>: o Records storage areas in residences
	Facility Self-Assessment: The facility's self-assessment, called the POI, was submitted to the monitoring team. The POI was revised since the last onsite review. The new version was shorter and more likely to be useful to the facility. It listed the four provision items, what the facility did or planned to do for each provision item, and actions it had taken towards addressing five of the recommendations made in the previous monitoring report. MSSLC self-rated one provision (V1) as being in substantial compliance and the other three as being in noncompliance. The facility had made a lot of progress in its recordkeeping practices and in its work towards achieving substantial compliance with this provision. The monitoring team wishes to acknowledge these efforts. As indicated below, however, the monitoring team did not agree with this rating for V1 because more work needs to be done to achieve substantial compliance. Even so, it is very likely that MSSLC will do so in the near future. The monitoring team agreed with the facility's self-ratings for the other three provision items. Note, however, that progress was also occurring in those three provisions.
	Summary of Monitor's Assessment: Overall, MSSLC had made a lot of progress towards achieving substantial compliance with the items of this provision. Moreover, the director of client records and the two unified records coordinators were responsive to many of the recommendations and suggestions made in the previous monitoring report. 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. The new set of records followed the state's policy. A facility-specific policy was written and was submitted to DADS central office for review and approval. The active records and individual notebooks were organized according to the required format. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record. The nursing section, however, was very large and consideration should be given to either reducing the size or subdividing so that it is more manageable for all staff. Further, It would be helpful for there to be information as to what consents are appropriate and required for each individual, and an indication of what medical consultations should be in each individual's record. The medical director

	maintained a listing of all medical consultations. This listing might be useful to the recordkeeping department in this regard. Individual notebooks were also in place for each individual, however, MSSLC managers and clinicians reported many problems in using the individual notebooks in most of the units. The issues were primarily around the cumbersome and somewhat counter-therapeutic characteristics of the notebooks. A determination will need to be made as to whether the individual notebooks can be eliminated. If so, the facility will need to ensure that the original intentions for creating the individual notebooks are met via other processes. A complete set of state and facility policies had continued to grow since the last onsite review, but was not yet complete and comprehensive as required by provision V2. Two new spreadsheets were being used to manage and track the existence and development of both the state and the facility policies for each provision of the Settlement Agreement. The conduct of quality assurance reviews of the unified record was another area where continued improvement occurred since the last review. Thorough reviews of active records were conducted by the unified records coordinators. Moreover, unit record clerks were required to conduct reviews, too. The URCs developed and maintained a system to list, manage, and follow-up on all corrections that needed to be made following each review. The master record, however, was not yet part of the review process. If individual notebooks are going to remain, they will also need to be part of this quality review process. MSSLC had begun to look at ways to determine whether and how the unified records were used in making treatment decisions as specified in provision V4. The director of client records had been talking with the recordkeeping staff at San Antonio SSLC to pilot some of their procedures. This was good to see. It is likely that, ultimately, a set of activities will be required in order to meet the requirements of V4.

#	Provision	Assessment of Status	Compliance
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. DADS had developed a policy on recordkeeping called Recordkeeping Practices. It was numbered 020.1, was dated 3/5/10, and was adopted in full by MSSLC. In addition, MSSLC administration had recently approved a facility-specific policy, Recordkeeping, numbered Administrative Services-6, and dated 3/10/11. The director of client records had recently submitted it to DADS central office for review and was awaiting feedback and approval. The policy provided some direction for recordkeeping activities at the facility and appeared to be useful to staff and managers. There were two other facility-specific policies regarding recordkeeping. Both were being revised and will be reviewed	Noncompliance

#	Provision	Assessment of Status	Compliance
		during the next onsite review. They were Adm-14, Management of client confidential information; and Adm-30, Documentation of services delivered. At the time of this onsite monitoring review, 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 URCs and the unit record clerks were now focusing on maintaining these records. The completed unified record consisted of the following, as required: • Active record • Individual notebook • Master record • Overflow files Tables of contents for the active records and individual notebooks were adapted based on this facility's needs. All changes were clearly indicated on the table of contents. In addition, the state had recently given the facility updated tables of contents with an expectation of implementation in April 2011. The facility's records activities continued to be overseen by Elaine Schulte, Director of Client Records, and Sherrie Price and Misty Samuels, Unified Records Coordinators (URC). The URCs were energetic and motivated about meeting the items of this provision. They had taken initiative in a number of areas and were extremely responsive to suggestions and comments made by the monitoring team. There also continued to be five records clerks at the facility, one for each unit. The records clerks had primary responsibility for managing and maintaining the active records and individual notebooks. <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. The active records were constructed following the order of sections from the state's table of contents. The active records were divided across the binders in the same way for all individuals across the facility. A review of observation notes and IPNs in the active records indicated that they appeared to be in good format, easy to read, and ordered correctly, though the quality assurance reviews indicated that this was not always the case (note, this comment refers to the format and appearance of the observation notes and IPNs, not to their content; content is reviewed when applicable in the review of each provision of the Settlement Agreement in the other sections of this report).	

#	Provision	Assessment of Status	Compliance
		The PSP Coordinators completed a short checklist at the end of each annual PSP meeting to indicate which documents were completed and which, if any, were still needed for the active record. Three completed examples demonstrated that these were likely helpful tools for document management. The unit directors reported that, in their opinion, implementation of the new active records had not had any negative impact on service provision. The active records of a number of individuals were reviewed in some detail (see list above under Documents Reviewed). Overall, they were well organized, neat, and consistent. Below are some general comments. • PSPAs were well organized, easy to read, and it was easy to follow content from one meeting to the next. • The nursing sections of the active records were very large. The facility should undertake a review of what is in the nursing section and determine if it can be reduced or perhaps subdivided. • The URCs reported that various clinical staff had told them that it was difficult to find things in IPNs because there were so many nursing entries. • The recordkeeping department did not know what consents should be in the consents section because not every individual was required to have the identical set of consents. The director of client records reported that DADS central office was working on providing guidelines. • Similarly, the URCs and unit record clerks had no way of knowing what medical consultation documentation should be in each active record because these varied from individual to individual. During the onsite review, the monitoring team learned that the medical director maintained a listing of all consultations (e.g., podiatry, cardiac, vision). The recordkeeping department should consider obtaining this list so that URCs can know what documentation should be in the consultation sections of the active record. • The URCs created a way to list and track SPOs so that they could determine whether any were missing from the active record. <u>Individual notebooks</u> Individual notebooks existed for each individual, however, there was a lot of concern at MSSLC regarding the appropriate use of these books and there were questions regarding whether they could be eliminated. The concerns of managers and clinicians were also described in previous monitoring reports. In general, for many individuals at MSSLC, the individual notebooks appeared to be cumbersome to manage and potentially counter-therapeutic.	

#	Provision	Assessment of Status	Compliance
		Moreover, a notice from DADS central office in December 2010 allowed the SSLCs to do away with the individual notebooks, as long as they were able to meet a set of criteria, primarily centered around ensuring that information was readily available to direct care and clinical staff, and that a system was in place to allow accurate and reliable recording of pertinent data, such as the occurrence of problem behaviors, seizures, bowel movements, and performance on SPOs. The Settlement Agreement, however, specifically refers to the individual notebooks in Appendix D. The Monitoring Panel has recently had some initial discussions with DADS and DOJ regarding the individual notebooks and expects to be able to provide specific direction to the SSLCs in the next few months. Therefore, MSSLC should continue to maintain the individual notebooks until further direction is provided. The individual notebooks reviewed by the monitoring team appeared to contain most everything required by the facility's table of contents, however, they were in great disrepair, were missing sections of information, or were changed to larger hard binders instead of the original soft binders. This was probably due, in part, to the management staff's expectation that the individual notebooks might soon be discontinued. The facility had formed a work group to address the individual notebook issues at MSSLC. Even if the facility is allowed to, and then decides to, eliminate the individual notebooks for some of the residential units, the work group will still be useful to help the facility determine the processes it needs to put into place to make sure that the intent of the individual notebooks is met via other processes. The facility director had assigned the director of client records and the director of education and training to this work group. <u>Master records</u> Master records continued to be maintained by the director of client records and the URCs. MSSLC had a thorough table of contents for the master record. The monitoring team recommends that a standard table of contents across facilities be created. <u>Overflow files</u> Purged items were stored in excess folders by the unit record clerks and then sent to the URCs for organizing and storage at their office space. After two years, purged items were boxed and sent to a commercial storage facility. <u>Staff Perspectives</u> The monitoring team also had the opportunity to talk with staff across the campus	

#	Provision	Assessment of Status	Compliance
		regarding the active records and individual notebooks. • A direct care staff at the Shamrock unit with five years of experience said that she thought the individual notebooks were good for documentation. • A nurse on the Barnett Unit didn't like new active records. She said the binders were too large and heavy. She would prefer a separate medical chart. • A nurse on the Martin unit said that the active records help to tell her what's been going on for that individual.	
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 recently created a spreadsheet for each facility that showed the status of the state policy and the status of any facility-specific policies for each provision of the Settlement Agreement. MSSLC created a second spreadsheet that provided additional details regarding their facility-specific policies. These were managed by the QA director and the facility director's administrative assistant. These spreadsheets appeared to be useful for the facility to easily track the latest version of each state policy as well as ensuring that management was aware of where the facility stood in terms of the development of its own policies for each provision.	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.	The MSSLC URCs developed an excellent system of reviewing the active records. It consisted of four parts: • Review of a sample of active records by the URCs (usually 10 per month, that is, five were done by each of the two URCs) o The QA department conducted a reliability check by reviewing five of these 10. So far, there had been no disagreements. • Listing, in table format, all items that required correction from each review • Follow-up tracking of all items • Unit record clerks were required to conduct one review per week. o In addition, the unit record clerk at the Whiterock unit took extra initiative and did additional reviews of records. Reviews were submitted to the monitoring team for each month, November 2010 through February 2011, for the active records. Beginning in January 2011, the reviews were expanded from the statewide self-monitoring tool to also include a review of the active record based upon the table of contents. This was good to see and will be necessary if the facility is to achieve substantial compliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual notebooks were not reviewed, however, the monitoring team recommends waiting on a determination on the future of the individual notebooks before beginning to conduct reviews of the individual notebooks. Master records were not reviewed, but need to be. As a result of this work, MSSLC is close to achieving substantial compliance with this provision item. To do so will require inclusion of the master record (and possibly the individual notebook) in the record reviews. It will also require that there is some sort of summarizing of the data from the reviews in both a graphic/tabular format and in a short narrative that describes the highlights of the data. Moreover, the information should be tracked and trended over time and included in the facility's QA program. The information should include, for example, number of reviews conducted, number of deficiencies, and number of outstanding corrections.	
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.	DADS and MSSLC had taken some first steps towards addressing this provision item. Much more work will need to be done, however, to determine what activities the facility needs to engage in to demonstrate that records are being used as required by this provision item. The Monitoring Panel expects to work with DADS and DOJ over the next few months to delineate these activities. The director of client records had piloted a questionnaire developed earlier this year at the San Antonio SSLC. At the time of this onsite review, the survey was sent to five staff and only two had been returned. DADS had recently drafted another questionnaire. The Monitoring Panel reviewed this draft and has submitted comments and suggestions to DADS in a separate document. Another possible activity to this end might be to ask QAQI Council members to describe how each of their departments uses the records as per the requirements of this provision item. The answers might provide some direction to the recordkeeping department. These activities, however, are just one or two of a number of actions that each facility will need to take towards meeting this provision. 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. • At Individual #232's CLDP meeting his individual notebook was present, but was not used.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• At Individual #249's PSP meeting the RN case manager read from the SLP and audiology reports from the active record because those PST members were not present. • At Individual #6's PSP meeting his individual notebook and active record were present. During the meeting the active record volume 1 was open on the table. The psychologist looked through it at one point. • Individual books were not being used as intended for the more independent individuals (e.g., Whiterock and Longhorn units). • Physicians were documenting consultation summaries and recommendations in the records. Lab values were also frequently documented. The PCPs consistently documented summaries of neurology clinic assessments. The interpretation of these consultations and assessments should have provided valuable information for other members of the PSP. • Nurses frequently documented in the IPNs that they reviewed the past week's physician's orders for new/standing orders. They did not, however, document the outcomes of their reviews. • Nurses' notes were organized in the SOAP format, however, as noted in Section M, oftentimes the credentials of the nurses documenting the notes were illegible. • In the observed psychiatric clinic, the psychiatrist reviewed the medical record. Of concern, however, was when one of the facility psychiatrists informed the monitoring team that they had reviewed data sent via computer, but that this information was not formally entered into the individual's record. Lack of shared information contributed to outdated data affecting diagnostics and, thus, impairment of the PST's ability to make informed decisions.	

Recommendations:

1. Once a determination is made regarding the individual notebooks, improve the quality of the individual notebooks, or create an alternate system that meets the intention of the individual notebook.

2. Consider reducing the size of nursing section of the active record.

3. Complete task of determining what (a) consents and (b) medical consultation documentation should be in each active record.

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

5. Include the master record in quality assurance reviews. If individual notebooks are continued, include them in the quality assurance reviews.

6. Incorporate recordkeeping activities into the facility's quality assurance program, including ensuring the data collected by the recordkeeping

staff during their record audits are included in the QA program.

7. 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. With guidance from DADS central office, determine what activities and actions the facility must engage in. Determine a way to assess whether or not these are occurring.

The following are offered as additional suggestions to the facility:

9. DADS central office should consider whether or not to standardize the table of contents for the master records across SSLCs.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACLS	Advanced Cardiac Life Support
ACP	Acute Care Plan
ADA	Americans with Disabilities Act
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AICD	Automated Implantable Cardioverter Defibrillator
AIMS	Abnormal Involuntary Movement Scale
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APS	Adult Protective Services
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
ASAP	As Soon As Possible
AT	Assistive Technology
ATP	Assistive Technology Practitioner
BBS	Bilateral Breath Sounds
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BLS	Basic Life Support
BM	Bowel Movement
BMD	Bone Mass Density
BMI	Body Mass Index
BP	Blood Pressure
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BTC	Behavior Therapy Committee
CANRS	Client Abuse and Neglect Registry System

CAP	Corrective Action Plan
CBC	Criminal Background Check
CBC	Complete Blood Count
CC	Campus Coordinator
CCC	Clinical Certificate of Competency
CCP	Code of Criminal Procedure
CDC	Centers for Disease Control
CEU	Continuing Education Unit
CHOL	Cholesterol
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Assistant
CPEU	Continuing Professional Education Units
CPR	Cardio Pulmonary Resuscitation
CR	Controlled Release
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTA	Clear To Auscultation
CTD	Competency Training and Development
CV	Curriculum Vitae
DADS	Texas Department of Aging and Disability Services
DARS	Texas Department of Assistive and Rehabilitative 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
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM	Diabetes Management
DNR	Do Not Return
DNR	Do Not Resuscitate
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual

DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
e.g.	exempli gratia (for example)
EEG	Electroencephalogram
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMR	Employee Misconduct Registry
EPS	Extra Pyramidal Syndrome
ER	Emergency Room
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FOB	Fecal Occult Blood
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FX	Fracture
FY	Fiscal Year
GAD	Generalized Anxiety Disorder
G-tube	Gastrostomy Tube
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
H	Hour
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCS	Home and Community-Based Services
HCTZ KCL	Hydrochlorothiazide Potassium Chloride
HDL	High Density Lipoprotein
HIP	Health Information Program
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HMP	Health Maintenance Plan
HR	Heart Rate
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)
IED	Intermittent Explosive Disorder
IEP	Individual Education Plan
ILASD	Instructor Led Advanced Skills Development

ILSD	Instructor Led Skills Development
IM	Intra-Muscular
IMC	Incident Management Coordinator
IOA	Inter Observer Agreement
IPN	Integrated Progress Note
ISP	Individual Support Plan
IV	Intravenous
KUB	Kidney, Ureter, Bladder
L	Liter
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LOD	Living Options Discussion
LOS	Level of Supervision
LSOTP	Licensed Sex Offender Treatment Provider
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAR	Medication Administration Record
MBA	Master Business Administration
MBS	Modified Barium Swallow
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MERC	Medication Error Review Committee
MG	Milligrams
MH	Mental Health
MISD	Mexia Independent School District
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Authority
MRA	Mental Retardation Associate
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphyloccus Aureus
MS	Master of Science
MSSLC	Mexia State Supported Living Center
MVI	Multi Vitamin
NA	Not Applicable
NA	Sodium
NAN	No Action Necessary

NAR	Nurse Aide Registry
NC	Nasal Cannula
NCP	Nursing Care Plan
NEO	New Employee Orientation
NGA	New Generation Antipsychotics
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
ODD	Oppositional Defiant Disorder
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P&T	Pharmacy and Therapeutics
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCI	Pharmacy Clinical Intervention
PCN	Penicillin
PCP	Primary Care Physician
PEG	Percutaneous Endoscopic Gastrostomy
PERL	Pupils Equal and Reactive to Light
PET	Performance Evaluation Team
PFW	Personal Focus Worksheet
Pharm.D.	Doctorate, Pharmacy
Ph.D.	Doctor, Philosophy
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
PO	By Mouth (per os)
POI	Plan of Improvement
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)
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
QE	Quality Enhancement
QAQI	Quality Assurance Quality Improvement
QDRR	Quarterly Drug Regimen Review
QHS	quaque hora somni (at bedtime)
QMRP	Qualified Mental Retardation Professional
QTR	Quarter
R	Respirations
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner
RPH	Registered Pharmacist
RR	Respiratory Rate
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SATP	Substance Abuse Treatment Program
SIB	Self-injurious Behavior
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPO	Specific Program Objective
SSLC	State Supported Living Center
STAT	Immediately (statim)
STOP	Specialized Treatment of Pedophilias
T	Temperature
TD	Tardive Dyskinesia
TED	Thrombo Embolic Deterrent
TG	Triglyceride
TSH	Thyroid Stimulating Hormone
UIR	Unusual Incident Report
URC	Unified Records Coordinator
UTI	Urinary Tract Infection
VIT	Vitamin

VNS	Vagus nerve stimulation
VPA	Valproic Acid
VS	Vital Signs
WNL	Within Normal Limits
WT	Weight
XR	Extended Release