United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of Onsite Review: September 19-23, 2011

Date of Report: December 6, 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.

Table of Contents

Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), 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.

Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement. Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the parties.

In order to conduct reviews of each of the areas of the Settlement Agreement, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and 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.

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple 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 can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

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 of the review, 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. **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. The Monitoring Team made additional requests for documents while on site. 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.

(b) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, 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, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.

(c) **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.

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 addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that 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 Settlement Agreement, 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 Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, 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:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, 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. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.
g) **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 form the parties to protect the confidentiality of each individual.

Executive Summary

First, once again, the monitoring team wishes to 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 interim facility director, Iva Benson, was extremely supportive of the monitoring team's activities throughout the week of the onsite review (also see below). She was present throughout the campus, present at many different meetings, available as needed, and responsive to monitoring team requests.

The Settlement Agreement Coordinator, Etta Jenkins, was assigned primary responsibility for coordination of document preparation and coordination of activities during the onsite review. Ms. Jenkins, whose work the monitoring team fully respects and appreciates, did an outstanding job during the weeks prior to, during, and after the onsite review. She was well organized, followed-up thoroughly when needed, and ensured that the monitoring team had what it needed to conduct this review. She was assisted by Bobbie Hall and Sandra German. They, under Ms. Jenkins' supervision, were also very professional and helped with many aspects of the monitoring review process.

Second, management, clinical, and direct care professionals continued to be 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. 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, 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.

- Transition of senior leadership: The long-term facility director and assistant director of programs both retired from the facility about a month prior to this onsite review. Ms. Iva Benson was appointed as interim facility director. During the few short weeks of her assignment, she had become an active participant in many aspects of the facility's operation. She led and attended many meetings and fostered communication across departments and divisions. She created or revised management groups, the QAQI Council, Performance Evaluation Teams, and Performance Improvement Teams. She took quick action when needed and ensured that follow-up occurred. She included all managers and clinicians in this process and regularly referred to services

by their Settlement Agreement provision letter. As a result, management was becoming active in addressing the Settlement Agreement, more knowledgeable about its requirements, and more fluent in discussing its contents. This had set the occasion for the provision of integrated clinical services, PSP supports, and services.

- Role of unit directors: Even though no provision items are specifically assigned to them as leads, the five residential unit directors play a very important role in the facility's ability to meet the requirements of the Settlement Agreement because their staff and middle managers must implement the direct services and supports that are provided to the individuals. During the onsite meeting with the monitoring team, the unit directors talked about their recent increased inclusion in Settlement Agreement related activities, such as the QAQI Council and PETs. They talked about pilot projects and working with other departments. The monitoring team enjoyed meeting with the unit directors and appreciated their candidness and the many examples they provided.

- Turnover of medical staff. The medical director had worked for many years at MSSLC. There was, however, much turnover in the group of PCPs, psychiatrists, and pharmacists. This appears to be an ongoing challenge that needs to be addressed by MSSLC. It may be that turnover in medical staff will be the status quo for the foreseeable future. Therefore, the facility should consider ways of managing regular turnover. Specialized orientation and supervision might be considered to help ease the transition of new physicians and other medical staff into MSSLC, the DADS system, and the Settlement Agreement.

- Ongoing projects:
    - At-risk processes: After some fits and starts, there appeared to be a more solid focus on implementing the state's required processes for assessing and managing risk at the individual level.
    - PSPs: The facility continued to work hard on improving the PSP process. A new revision to the process was in the works and the facility was preparing for additional training from DADS and its PSP consultants.

- Facility self-assessment: MSSLC provided its facility self-assessment, called the POI. The development of a useful POI has been an ongoing project for all of the SSLCs. Future revisions will be done in collaboration with DADS central office. In each of the sections of this report, the Monitor comments on the POI. Overall, the MSSLC POI described actions the facility had taken that, in its opinion, were moving the facility towards substantial compliance, and actions it planned to take in the future. While this information was useful to the monitoring team, the POI should describe
    - The activities the facility engaged in to conduct the self-assessment of the provision. This might include sampling, observations, implementation of their self-assessment tools, etc.

- How the facility used the findings from these activities to determine substantial compliance or noncompliance.
- A self-rating of substantial compliance or noncompliance.
- Action steps/activities the facility planned to engage in to work towards substantial compliance.

- Monitoring tools. DADS central office had distributed self-monitoring tools that lined up with most provisions of the Settlement Agreement. These tools were meant to be more user-friendly and appropriate for use by facility staff than were previous versions. Additional attention will need to be made to ensure the tools are updated and that they are implemented reliably (see section E below). At MSSLC, these tools were being taken very seriously, that is, they were being used regularly and data were reviewed regularly. As the facility moves forward with this process, the monitoring recommends the following considerations (also see section E below):
  - Make sure the content of each tool is appropriate and correct. Revisions are needed. Some items in each tool will need to be reworded, others deleted, and others added. This activity will need to occur along with DADS central office.
  - There should be correspondence with the monitoring team's ratings. That is, high ratings should correspond with substantial compliance, and low ratings should correspond with noncompliance.
  - Scores on these tools should also have some face validity with department leadership's more subjective opinions.
  - Create two graphic presentations of the data, one that shows a single data point for each month's total, and a second presentation that presents the data for each item of the tool for only the current month.
  - Be thoughtful about the assessment of reliability such that it is being used to ensure interobserver agreement and to set the occasion for training and collaboration.

Fourth, 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

- In the past six months, 499 restraints occurred; 103 individuals were the subject of restraints; and 16 individuals had more than five restraints. Of these, one individual had 121 restraints, one other had 40 restraints, and one other had 27 restraints. Of the 499 restraints, 312 were physical restraints, 150 were the use of mittens or helmets, and 37 were chemical restraints. In addition, the facility reported 58 incidents of restraint used for medical and/or dental treatment.
- Although there had not been a significant reduction in the use of restraints since the last monitoring visit, facility management and the psychology department, had focused on the individuals with the highest number of

restraints at the facility. This had been effective and those three individuals no longer appeared on the list of individuals with the greatest number of restraint incidents.

- Since the last monitoring visit, video monitoring of a sample of restraints was being used to review compliance with implementation requirements. Further, an audit process was in place to review restraint documentation for compliance with section C requirements, and Restraint Debriefing, Review, and Face-to-Face Assessment for Crisis Intervention forms were completed with much more detail than was found during previous monitoring visits. Restraint monitors were including more information that would be helpful to the PST in addressing behavioral incidents leading to restraint.

Abuse, Neglect, and Incident Management

- MSSLC continued to consistently investigate all allegations and incidents. As was noted in the last monitoring report, the facility had a good system in place for dealing with the massive number of incidents and investigations. Nevertheless, it remains a concern of the monitoring team that individuals at the facility were at high risk for harm in their current environment.
- Investigation of 818 allegation of abuse, neglect, or exploitation were conducted by DFPS in the past six months. Of these 818 allegations, 27 (3%) were confirmed allegations by DFPS (including 10 allegations of physical abuse, one allegation of emotional/verbal abuse, and 16 allegations of neglect), 326 (40%) were unconfirmed allegations, 10 (1%) were inconclusive, 129 (16%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect, and 324 (40%) were unfounded.
- There were an additional 73 serious incidents at the facility that did not involve allegations of abuse or neglect included in trend reports for last six months. These incidents were investigated by the facility investigators.
- There were a total of 1590 injuries reported between 2/1/11 and 7/31/11, including 25 serious injuries resulting in fractures or sutures. Consideration should be given to factors that generally contribute to injuries and incidents at a large facility, such as crowded living areas, inappropriate levels of supervision, and lack of meaningful activities. Individuals involved in incidents were generally assigned one-to-one supervision to try to reduce the occurrence of incidents. Numerous incidents were documented where individuals displayed increased aggression related to being placed on a heightened level of supervision. A number of confirmed allegations of abuse and neglect occurred during behavior incidents that escalated when staff did not use appropriate intervention strategies.
- Interagency meetings continued to be held quarterly with MSSLC, DFPS, and OIG administrative personnel to address systemic issues. The interagency committee had developed action steps to try to minimize the length of investigations and support better cooperation among investigative agencies. Interagency meetings with DFPS, OIG, and the facility were a positive step towards resolving issues regarding outside investigations.

Quality Assurance

- MSSLC made little progress towards establishing a comprehensive quality assurance program. This was due, in large part, to continuing turnover in the QA director position.
- Progress was evident in the improvement and expansion of QAQI Council and related committees and meetings.
- QA policy was not yet developed and a QA plan was not fully in place (a table/matrix existed, but it was insufficient as a QA plan). A QA report did not exist. A system of managing corrective actions was not yet in place.
- QA staff were competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. QA staff collected a variety of data, and conducted a variety of audits.

Integrated Protections, Services, Treatment, and Support

- The facility was still considering how to best implement the person centered planning process and ensure consistent implementation and monitoring of services. All staff had also been trained on the new risk identification process and the process had just been implemented for some individuals at the facility. DADS had recently hired a set of consultants to help the SSLCs move forward in PSP development and the meeting of this provision's requirements. The consultant's work had not yet begun at MSSLC.
- A number of PSP meetings were observed by the monitoring team. In meetings observed, the QDDPs were attempting to encourage team participation and ensuring that all necessary information was covered during the PST meeting. Most of the information regarding assessments and supports was presented by individual team members and very little discussion took place among team members to integrate information shared.
- Quality assurance activities with regards to PSPs were in the initial stages of development. Audit tools had been developed to review both meeting facilitation and the PSP development process. The facility had been using the state developed audit tools since May 2011. The facility used data gathered through this process to determine compliance with each provision.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- MSSLC continued to make progress with provision G and was taking action to address it, but was not taking much action yet towards provision H. The medical director was the lead for these provisions and was aware of its importance. Evidence of integration efforts on the part of numerous disciplines was presented to the monitoring team during the conduct of this review.
- Notwithstanding these efforts, most areas required additional work to ensure that integration resulted in the desired clinical outcomes for the individuals. This will likely occur as the processes are refined and the facility fully embraces a culture consistent with the provision of integrated services. The strategic move to appoint the

facility director as the lead for this provision should foster a greater sense of collaboration and accountability among the various disciplines.

- MSSLC is in need of further direction by guidance from state issued policy. Additionally, a valid and reliable monitoring tool is needed. This will require that the facility determine what it needs to measure and identify the metrics that will be utilized for measurement.
- As these provisions encompass all clinical services, it will be critical for all clinical departments to have extensive involvement with further development. It is recommended that the facility's QA department play a role in addressing this provision.

At-Risk Individuals

- The state had taken a number of steps to support positive results in the area of risk management, including forms for identifying risk, a risk action plan requirement, risk guidelines, and an initiative regarding aspiration pneumonia.
- Each individual's PST was responsible for risk assessment and management, as well as ongoing risk review and addressing changes in status. 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.
- PSTs were not accurately identifying risk for individuals, even with the new process. 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.

Psychiatric Care and Services

- The psychiatry department at MSSLC had seen some improvement with designated space provided for the clinic, and administrative assistance in the form of two psychiatric assistants. The clinic was more organized, the psychiatrist received clinical information during clinic, and discussions regarding the individuals were more detailed.
- There were marked deficits in the interaction between psychiatry and psychology. It was apparent that some 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 clinical indicators/target symptoms, data collection, collaboration regarding case formulation). Frequent psychiatric staff turnover and history of a lack of consistent clinical resources in psychiatry, which did not lend itself to close collaboration.

- The facility staff must create a system for the provision of psychiatric services. Approaching section J to accomplish a comprehensive, collaborative, integrated psychiatric subspecialty service to the individual and other disciplines is required.

Psychological Care and Services

- There were several improvements since the last onsite review, including the addition of a Board Certified Behavior Analyst, increased flexibility in the data system, the use of more informative graphs, establishment of a data collection project designed to improve reliability, and establishment of evidence-based curriculums, goal directed services, and measurable treatment objectives for psychological therapies, other than PBSPs. Further, there were improvements in Positive Behavior Support Plans and in the development of a list of approved behavioral procedures.
- The monitoring team suggests that the facility focus on ensuring that all group and individual therapies include fail criteria, and service plans include procedures for generalization of acquired skills. In addition, the facility needs to ensure that target and replacement behavior data are reliable and should begin the collection of IOA data for target behaviors. A method to ensure that PBSPs are implemented with integrity and that all functional assessments include all the necessary assessment components, and have a clear summary of the variables hypothesized to affect target behaviors is needed.

Medical Care

- The medical department was comprised of locum tenens physicians, however, the department benefited from the leadership of a long-term medical director. There was one physician assistant who had recently taken on the primary responsibility for a caseload. All of these practitioners appeared eager to meet the needs of the individuals.
- Generally, the medical staff responded to the acute and chronic needs of the individuals. Problems were noted with the provision of certain preventive care services. Records reviewed also indicated that follow-up was at times inadequate as abnormal findings and/or results sometimes were not addressed for many months. The department implemented several databases that should have provided the ability to track services and ensure consistent care
- The department had not developed any clinical guidelines since the last visit, other than the laboratory matrix. In the absence of established clinical guidelines, development of a robust medical quality program will be difficult to create.
- External medical reviews were completed, deficiencies identified, and corrective actions implemented. The medical department also self-audited five records each month. Both of these evaluations were process driven, actual clinical outcomes were not assessed.

Nursing Care

- MSSLC was making progress toward meeting many of the provisions of Section M. Since the prior monitoring review, the Nursing Department had undergone additional positive changes in staff members who occupied positions of leadership within the Department.
- There was also evidence that new systems were being developed and implemented and existing systems were being improved to help ensure that individuals' health needs and risks and the changes in their health status would be more promptly identified and addressed.
- Notwithstanding these positive and notable findings and despite MSSLC's efforts to provide training, re-training, monitoring, and monitoring the monitors, there were many occasions when nurses, as well as direct care staff members, failed to properly implement planned interventions, policies, and procedures to ensure individuals health and safety.
- For example, the review revealed problems with nurses who failed to respond appropriately to ensure adequate follow-up for individuals who had suffered injury and showed signs and symptoms of possible infection and/or illness. There were episodes of improper nursing practice that included nurses who failed to follow proper procedure during enteral feeding, which put individuals at risk of aspiration; nurses who failed to properly perform wound/skin care, which put individuals at risk of infection; and nurses who failed to safely administer medications, which put a number of individuals at risk of harm.

Pharmacy Services and Safe Medication Practices

- The pharmacy department demonstrated limited progress since the last review. Several areas showed signs of regression. The lack of a stable pharmacy staff was likely a contributing factor. Each of the three monitoring team's compliance visits was completed under the leadership of a different pharmacy director.
- Documentation of communication between pharmacists and providers continued, but there had been no consolidation of the tracking tools resulting in the use of multiple documents. The number of documented interactions between the pharmacists and medical staff decreased sharply in April 2011, which coincided with the change in pharmacy leadership.
- The QDRRs were completed, but the quality of the reviews appeared to have diminished since the previous visit.
- Adverse drug reaction reporting increased substantially, but the quality of the data submitted indicated that additional work was needed in this area. The data submitted, potentially alluded to problems with the use of certain classes of drugs.
- Drug utilization evaluations were completed and provided good educational information in addition to data on the facility's use of the agents reviewed. Once again, there was no evidence that corrective actions were taken to

address the problems noted. Moreover, the connection between the ADR system, DUE evaluations and the QDRRs appeared unrecognized as data from one process never seemed to link to the others.

- Medication errors remained a serious cause for concern. There was no validation process in place. Hundreds of medications continued to be returned to the pharmacy, and there was no means of reconciling liquid medication.

Physical and Nutritional Management

- The Habilitation Therapies department demonstrated a lot of effort with a substantial number of work products produced related to this provision and to section P. There were many new systems initiated.
- The PNMT at MSSLC was a fully constituted, dedicated team. While a number of meetings had been held since the previous review, the team had completed an assessment for only one individual. There was, however, no action plan developed. The facility was significantly behind in the development of this team.
- The PNMPs were of a consistent format and each was current within the last 12 months. Implementation of these plans, while improved, continued to be problematic and staff did not understand the rationale for the strategies they were instructed to apply.
- Positioning and transfers continued to be a concern. Supervisors and monitors were not recognizing the problems and/or were not take sufficient corrective actions to address them. PNMP monitoring must also address the question of whether interventions are effective.
- The PSTs will require ongoing 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.

Physical and Occupational Therapy

- The assessment process observed during this review had significantly improved. The report content had also improved, though there was no analysis of findings to establish a rationale for the supports and services provided or to justify why direct supports were not indicated.
- The health risks identified by the PST were not identified or addressed in any way. In addition, there was no evidence that pertinent health and medical concerns were considered because there was no analysis of findings or documentation of clinical reasoning. A discussion of health risk issues with a description of functional limitations, skill abilities, and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs, are essential elements to an appropriate clinical assessment.
- The OT and PT clinicians conducted their annual assessments together and in some cases the SLPs participated in the assessment process as well. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and to review other supports and services. The assessment observed during this onsite review was a good example of this.

- There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, extremities not adequately supported, or the pelvis not well back into the seat of the wheelchair.

Dental Services

- The dental department made little progress towards substantial compliance. Moreover, this review was challenged by a lack of key information submitted to the monitoring team. This issue surfaced in the September 2010 review and was more pronounced in the March 2011. For this review, 40% of the items requested were responded to with "none" or not available.
- Another disconcerting issue was noted in the data that were submitted. The facility continued to report that no oral sedation or chemical restraints were utilized. Numerous individuals, however, were sent to a local medical facility for a variety of procedures, including simple extractions, which involved the use of conscious sedation and general anesthesia.
- Collaboration between the medical and dental directors was lacking and this made moving towards compliance even more difficult. This was a disappointing finding since this issue was discussed during the last review and a recommendation was made for the medical director to have more frequent contact with the dental director and provide more support and guidance.
- The facility lacked a formal process to address the issue of failed appointments and refusals. Many individuals were brought back to clinic for informal desensitization, but there was no threshold set for referring these individuals for desensitization plans. The result was many individuals who repeatedly refused treatment and sometimes, ultimately, required multiple extractions.

Communication

- There were only 28 of individuals who had not yet received an assessment. It was of concern, however, that very few new systems or objectives had been provided, based on the assessments, especially for those individuals identified as nonverbal or partially verbal. This brought into question the validity of the findings of these assessments (as well as their functionality and usefulness).
- There were 120 individuals with a Communication Dictionary only. This was for staff to interpret communicative efforts by the individual. It did not enhance or augment the individual's communication abilities. Only four individuals received some type of direct communication intervention. SLPs were not involved in the development of SPOs. Despite all this, the clinicians reported that all individuals with potential to benefit from AAC had been evaluated and that each individual's needs had been met.

- Consistent implementation of AAC systems continued to be a concern. Direct support staff did not appear to be knowledgeable regarding communication programs. No communication systems were observed being used. There were no general use devices noted.

Habilitation, Training, Education, and Skill Acquisition Programs

- 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.
- Several improvements were noted since the last review, including that Specific Program Objectives (SPOs) had been revised to include a rationale for the program, a new engagement monitoring team was established, and there was a new tracking methodology for training activities in the community. MSSLC began to incorporate replacement behaviors in the SPO format and there were improved individual engagement scores.
- The facility should focus on expanding the new SPO format to all SPOs, ensuring that the rationale for each SPO clearly states how acquiring this skill is related to the individual's needs/preference, and ensuring that all of the components necessary for learning new skills are included in each SPO. The facility should also expand the methodology used to teach SPOs and collect and track SPO integrity measures

Most Integrated Setting Practices

- MSSLC continued to make progress towards meeting provision T. Many individuals continued to be referred for placement and many continued to be placed in community programs all over the state. The number of individuals in the referral process and being placed appeared to be manageable and appropriate. Progress had been made in placing individuals who had been referred for more than 180 days.
- The monitoring team recommends that the department's data be summarized and graphed every six months, and that the data be incorporated into the facility's QA program. Thorough reviews of any failed placements, including individuals who, after moving to the community, died, were jailed, were admitted to a psychiatric facility, or returned to MSSLC need to occur.
- The opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required. Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. Another revision to the PSP process was recently initiated under the guidance of three DADS consultants. The consultants will need to work closely with the DADS coordinator of most integrated setting practices to ensure that the requirements of provision T are included, such as the LOD. Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility.

- A number of activities were occurring to educate individuals and their LARs, however, this needs to be individualized and incorporated into the PSP. Feedback obtained from some of these activities (e.g., provider fair, community tours) should be used by the APC for future planning.
- The new CLDP process had only recently been implemented. Soon to occur was the initiation of the CLDP at the time of referral. There continued to be serious problems with the facility's ability to develop an adequate list of essential and nonessential supports in the CLDP. Instead, most focused primarily on the provision of inservices, the scheduling of appointments, and the presence of items and plans rather than their use and implementation. There were few supports that were directly related to actions that were to occur day to day for each individual, such as implementation of preferred activities,.
- Post move monitoring had improved since the previous review. Site visits were occurring regularly, reports were being completed, and the four staff directly involved in doing post move monitoring were professional and committed to doing a good job. A number of further improvements, however, are necessary for the facility to achieve substantial compliance with post move monitoring.

Consent

- A new Human Rights Officer had been hired and designated as the responsible person for overseeing compliance with Section U requirements. The facility had updated a list of individuals and their guardianship status and information on guardianship was mailed to families. The Human Rights Officer had made contact with advocacy and guardianship agencies in the area.

Recordkeeping Practices

- MSSLC demonstrated continued progress. The department director, the two URCs, and the home record clerks continued to be very serious about their jobs and had responded to many of the recommendations and comments from the previous monitoring report.
- The URCs had begun to summarize and graph data from some of their activities. Graphs indicated the number of corrections required after each monthly audit of the active records, and the number of corrections that were still not completed after a two-month "window" that was allowed for corrections to be made.
- The active records were neat and organized. Many documents, however, were not submitted for filing or were submitted late. Active record volumes were often missing from their assigned location, were not signed out by staff, and disappeared and reappeared. Other documents were sometimes missing from the active record, that is, documents were found to be absent, such as SPOs. Legible content and signatures, and inclusion of credentials needed to be improved for the IPNs.

- MSSLC had not yet made an active decision regarding how to proceed with the individual notebooks. This was surprising given the serious problems with the individual notebook system at MSSLC, as detailed in the previous monitoring report.
- MSSLC had master records and a checklist table of contents. Many items on the list were not available. The next step is for the facility to determine what to do about the many items that were missing (e.g., determination of mental retardation, birth certificate).
- The URCs conducted reviews of at least five records each month. They did not, however, include the master record in those reviews. Also, many of the monthly audits did not include the individual notebook because it was often not available at the time of day the URC conducted her review. Overall, the reviews that were completed were done so in a consistent manner. Two forms were completed for each review. One was the statewide monitoring tool. The other was the table of contents for the active record and individual notebook. There was a consistency in the issues and problems identified by the URCs. A few of the reviews indicated that there was falsification of records. This should be thoroughly examined.
- To address the facility's use of the unified records to make treatment and care decisions, the recordkeeping staff had done two brief interviews of a PST member. More activities will need to be undertaken.

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.

II. 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 Policy: Use of Restraint Policy dated 9/8/10 o MSSLC Plan of Improvement o MSSLC Restraint Trend Analysis for FY11 o MSSLC Section C Presentation Book o MSSLC "Do Not Restrain" list o List of all restraints used for crisis intervention for the past six months o List of all chemical restraints for the past six months o List of all medical restraints for the past six months o Documentation for medical restraint for: o Individual #293 – medical mechanical 8/1/11 o Individual #165 – pretreatment sedation 7/19/11 o Individual #185 – pretreatment sedation 7/21/11 o Individual #278 – pretreatment sedation 7/11/11 o Individual #438 – pretreatment sedation 7/13/11 o Individual #151 – medical mechanical 7/18/11 o Individual #365 – medical mechanical 8/1/11 o Individual #518 – medical mechanical 8/1/11 o List of all dental restraints for the past six months o List of individuals with dental desensitization plans o Dental desensitization plans for Individual #481, Individual #196, Individual #500, Individual #369, and Individual #456. o Restraint Reduction Committee meeting minutes since 2/1/11 o List of all individuals who had a Safety Plan o Training transcripts for 24 MSSLC employees o Special Restraint Review Tracking Log 12/03/10 – 7/27/11 o Investigation documentation for DFPS case #40214315, #39222987, #38917707, and #40008087 o Sample of Daily Incident Review Team Meeting Minutes for each Monday for the last six months o PSPs, Positive Behavior Support Plans (PBSPs), PSPAs, and Safety Plans (if applicable) for: • Individual #165, Individual #185, Individual #278, Individual #438, Individual #151, Individual #365, Individual #518, Individual #126, Individual #483, Individual #595, Individual #385, Individual #153, and Individual #331. o A sample of restraint documentation for behavioral intervention including: • Individual #126 – mechanical 6/22/11, mechanical 6/23/11 (3), mechanical 6/24/11

	• Individual #595 – physical 5/23/11 (6), physical 4/2/11 (3), chemical 4/2/11, physical 5/31/11, and physical 3/30/11 • Individual #483 – physical 4/9/11, physical 5/9/11, physical 6/26/11, physical 7/19/11, physical 7/29/11, physical 8/2/11, physical 8/7/11, and physical 8/15/11 • Individual #519 – physical 8/17/11 and physical 8/31/11 • Individual #591 – physical 5/17/11 • Individual #268 – physical 8/17/11 • Individual #209 – physical 9/9/11 • Individual #355 – physical 8/1/11 • Individual #367 – physical 8/31/11 • Individual #123 – physical 8/31/11 (2) • Individual #406 – physical /chemical 5/12/11 and chemical 5/24/22 • Individual #588 – chemical 7/21/11 • Individual #385 – physical 8/12/11 • Individual #153 – physical 8/13/11 • Individual #331 – physical 8/15/11 <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 Terri Moon, Human Rights Officer 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 9/19/11 o Longhorn Daily Unit Meeting 9/21/11 o Restraint Reduction Committee Meeting 9/22/11 o Human Rights Committee Meeting 9/20/11 o PSPA meeting for Individual #37 o Annual PSP meetings for Individual #360 and Individual #123 o Morning clinical services review meeting, 9/23/11
	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. It was updated on 9/8/11. In addition, during the onsite review, the Director of Psychology reviewed the presentation book for this provision.

	The POI indicated that the facility was using video to review restraint incidents and look for trends and systemic issues in the implementation of restraints. Additionally, the facility reviewed restraint documentation for compliance with section C requirements. The Director of Psychology self-rated the facility as being in noncompliance with seven out of eight provision items. The POI indicated that the facility self-rated itself as being in substantial compliance with C2. Although documentation reviewed indicated that individuals were released from restraint in compliance with this provision, the monitoring team did not find that documentation was sufficient to support substantial compliance. The monitoring team found the facility to be in compliance with training requirements in C3. The facility POI indicated that the audit found 100% compliance with training mandates. It was not clear why the facility rated itself as noncompliant with C3. The remaining seven provisions were found to be out of compliance. The action steps included in the POI were statements of action that had been completed since the last monitoring visit. The facility will need to develop a plan to monitor compliance and address any findings from this self-monitoring process. The facility had made some progress in addressing restraint issues for specific individuals who were the subject of the greatest number of restraints during the last monitoring visit. The facility needs to ensure that a process is in place to identify and address trends or systemic issues in regards to restraint application, monitoring, and documentation.

	Summary of Monitor's Assessment:
	
	In response to a request for a list of individuals restrained in the past six months, the facility provided a list of restraint incidents for all categories of restraints. Based on this list:
	• 499 restraints occurred;
	• 103 individuals were the subject of restraints;
	• 16 (16%) individuals had more than five restraints.
	  o Individual #126 had the greatest number of restraints with 121 (24%),
	  o 40 (8%) involved Individual #483,
	  o 27 (5%) involved Individual #595.
	• 312 (63%) were physical restraints;
	• 150 (30%) were mechanical restraints (mittens or helmet); and
	• 37 (7%) were chemical restraints.
	
	Restraint trending was reviewed for restraints documented occurring from 3/1/11 to 7/31/11. The facility had not yet gathered restraint data for August 2011 at the time of the monitoring visit. Based on information provided by the facility regarding restraints used for crisis intervention:

	• 269 restraints occurred, • 113 (42%) were emergency restraints, and • 156 (58%) were programmatic restraints. From 3/1/11 through 8/1/11, the facility reported 58 incidents of restraint used for medical and/or dental treatment. • 58 restraints occurred; • 26 individuals were the subject of medical restraints; • 28 (49%)were chemical sedation; • 29 (50%) were mechanical restraint (mittens or helmets); and • 1 (1%) was a personal hold. There had not been a significant reduction in the use of restraints since the last monitoring visit. The facility, particularly the psychology department, had focused on the individuals with the highest number of restraints at the facility. This had been effective at reducing the number of behavioral incidents leading to restraints for those individuals. Those three individuals no longer appeared on the list of individuals with the greatest number of restraint incidents. According to the facility POI, action taken by the facility to address compliance with section C since the last monitoring visit included: • Video monitoring of restraints was being used to review a sample of restraint incidents for compliance with implementation requirements. • An audit process was in place to review restraint documentation for compliance with section C requirements. • The Behavioral Committee was meeting weekly and reviewing restraints for individuals with more than three restraints in a 30-day period. • Restraint Debriefing, Review, and Face-to-Face Assessment for Crisis Intervention forms were completed with much more detail than was found during previous monitoring visits. Restraint monitors were including information that would be helpful to the PST in addressing behavioral incidents leading to restraint. The facility remained out of compliance with seven of the eight provisions in section C. The monitoring team found the facility to be in compliance with C3 regarding training on the implementation of restraints. There had been minimal effort to address concerns expressed by the monitoring team regarding the consistent implementation of behavioral strategies to reduce restraint incidents, revision of plans when strategies were not effective, and meaningful engagement.

#	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.	A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral incidents. Eighty-one individual were the subject of restraints used for behavioral intervention during the reporting period. The sample chosen consisted of 15 individuals (19%), including the three individuals with the greatest number of restraints and 12 other individuals (chosen by the facility). The individuals in this sample were Individual #126, Individual #483, Individual #595, Individual #591, Individual #519, Individual #268, Individual #209, Individual #355, Individual #367, Individual #123, Individual #406, Individual #588, Individual #385, Individual #153, and Individual #331. • Individual #126 accounted for 121 of 243 restraints reported for crisis intervention. A small sample (five instances) of restraint documentation was reviewed for Individual #126. Documentation was basically identical for each instance of restraint because he was in mittens daily for SIB behaviors. Documentation was reviewed for a sample of 35 (29%) of the remaining 122 restraints reported. <u>Prone Restraint</u> Based on facility policy review, prone restraint was prohibited. Employees were trained during New Employee Orientation and annual PMAB training, that prone restraint was prohibited. Based on a review of 40 restraint records for individuals in Sample #C.1 involving 15 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 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 40 restraint incidents. The following are the results of this review: • In 37 of the 40 records (93%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. The following were the three records that did not indicate an immediate and serious threat. o The restraint checklist for Individual #595 dated 5/23/11 at 6:26 pm indicated that he was restrained after coming at staff with a punching motion and cursing them. o The restraint documentation for Individual #406 on 5/12/11 indicated a horizontal restraint was implemented when he became aggressive towards staff. He was released from the horizontal restraint when he was calm and no longer a danger to staff. Following the restraint,	Noncompliance

#	Provision	Assessment of Status	Compliance
		documentation indicated that he was calm and sat down with staff for approximately 30 minutes. A nurse then spoke with him and he agreed to take a chemical restraint to help him "relax." Documentation indicated that he was calm when he received an injection of Ativan and Haldol. o A restraint checklist was not found for a chemical restraint administered to Individual #406 on 5/24/11. Nursing notes indicated that he received Haldol and Benadryl IM. The nursing notes documented "voluntarily – cooperative" at the time of the injection. For 35 restraint records in the sample, a review was completed of the description of events leading to behavior that resulted in restraint. (The five restraint checklists for Individual #126 were not used in determining compliance with the following items. His restraint was not contingent on his behavior at the time of restraint. His restraints involved wearing mittens to prevent SIB.) The checklists reviewed described the individual's behavior prior to the restraint, but only 19 (54%) restraints listed in the sample indicated either what activity the individual was involved in at the time of the restraint or what was occurring in the environment that might have triggered the behavior leading to restraint. • Some examples where events leading to restraint were adequately documented included: o The restraint checklist for Individual #595 dated 5/31/11 noted that the individual "…came back from staffing today and was upset because he misses his family…he says he just is getting homesick." o The restraint checklist for Individual #483 dated 4/9/11 noted, "…was resting on his couch in his room. Staff asked him if he would be more comfortable in his bed. He reached out and dug his nails into staff's arm." o The restraint checklist for Individual #591 dated 5/17/11 described the following events leading to restraint, "he walked away from unit because one of his peers beat him at basketball game." • Some examples where events leading to restraint were not adequately documented included: o The six checklists for Individual #595 dated 6/23/11 described the behavior that he was exhibiting, but did not indicate events that led to the behavior. For example, the checklist for 6:26 am stated, "…charges at staff attempting to swing and threat." o The restraint checklist for Individual #123 dated 8/31/11 described his behavior, but did not describe events leading to the behavior.	

#	Provision	Assessment of Status	Compliance
		• In 30 of 35 restraint records (86%), 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. The exceptions included: o The restraint documentation for Individual #406 dated 5/12/11 and 5/24/22 noted that he was calm prior to being given a chemical restraint on both dates. o The restraint checklist was missing for a restraint incident involving Individual #588 on 7/21/11. Observations notes did not indicate action that staff took prior to restraint. o The restraint checklists for Individual #483 dated 6/26/11 and 8/15/11 indicated that he was placed immediately into a horizontal hold. His SPCI stated that a basket-hold or bear hug should be attempted prior to horizontal restraint. 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 not evident that restraints were not used in the absence of, or as an alternative to, appropriate programming and treatment. Some examples where inappropriate interactions by staff may have contributed to behavior leading to restraint included: • The restraint checklist for Individual #483 dated 4/9/11 indicated that he was sitting on the floor following one restraint incident. Staff approached him to try to get him to go to his room or sit at the table with others. He began to display SIB. • Another restraint for Individual #483 dated 5/9/11 indicated that he was "having a good day" and he started arranging items on a table (this was noted to be "ritualistic" behavior for him). Staff intervened and asked him to stop. This led to his becoming aggressive towards staff. • The restraint incident for Individual #153 dated 8/14/11 indicated that he became upset with staff and began to walk off the home. He stated in his PSPA following the incident that he did not get along with the staff member assigned to him. There was no indication that swapping out staff, at least until he calmed down, had been considered prior to his behavior escalating. As noted above, documentation did not always indicate what activities individuals were involved in prior to restraint. Based on observations in the homes and day program	

#	Provision	Assessment of Status	Compliance
		building, there was progress made in overall engagement data being collected. Engaging individuals in more individualized and meaningful programming of interest would significantly reduce behavioral incidence leading to restraints. • Individual #483 had been assigned one-to-one staff to reduce self-injurious behaviors. During observation by the monitoring team, his support staff did not attempt to engage him in any meaningful activities. Interaction was limited to staff telling him to stop several times as he walked or ran around the yard area. • It was noted throughout the monitoring visit, that one-to-one staff often appeared to be "guarding" individuals rather than providing supports and meaningful interaction. • It was noted throughout documentation that individuals at the facility viewed increased supervision levels as punishment rather than support. <u>Approved Restraint Techniques</u> Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 40 restraints, 40 (100%) were documented as approved restraints techniques. The Director of Psychology, Campus Coordinator Supervisor, and program monitors were completing video reviews of some restraints. Inappropriate restraints viewed were being reported as abuse to DFPS. A review of investigations for section C of this report supported that this was routinely occurring. • DFPS case #40214315 was a confirmed allegation of physical abuse. Staff "body slammed" an individual to the floor during a restraint incident. • In DFPS case #39222987, it was found that one employee used excessive force to restrain an individual and another employee used inappropriate restraint techniques. • In DFPS case #38917707, physical abuse was confirmed against the alleged perpetrator (AP) for an unjustified restraint that did not conform to approved restraint techniques. • In DFPS case #40008087, an allegation of physical abuse was unconfirmed by DFPS. The facility reviewed the findings and revised the finding to confirmed. Evidence gathered regarding the events surrounding the incident included Integrated Progress Notes stating that the individual was "given Benadryl (50 mg) by mouth to help him calm down." The nurse later reported that the Benadryl was given for hives. In August 2011, seven of 11 reviews had recommendations for additional staff training in restraint implementation due to the use of unapproved restraint techniques.	

#	Provision	Assessment of Status	Compliance
		Dental/Medical Restraint The facility provided a list of medical pretreatment sedation/ medical restraints between 2/1/11 and 7/31/11: • 22 individuals were the subject of restraints, • 28 incidents of restraint occurred. • 26 incidents were for medical procedures, and • 2 incidents were for dental procedures. Restraint documentation and PSPs were reviewed for a random sample of seven individuals that had been the subject of medical restraint. The findings of this review are discussed in C4. 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 all interventions attempted prior to restraint. Further, it was not evident that adequate treatment and programming was being consistently implemented that might reduce the number of behavioral incidents leading to restraint. Even so, the monitoring team wishes to acknowledge the efforts taken by the interim facility director to focus attention on restraint reduction as evidenced in a number of different administrative meetings. For example, during one of the morning clinical services review meetings, she spoke eloquently and passionately about the importance of examining every use of restraint, and never becoming complacent about the use of restraint, even though they served a very challenging population at MSSLC.	
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 15 individuals in Sample #C.1 were reviewed. Of these, nine of the individuals had a Safety Plan for Crisis Intervention (SPCI). SPCIs were reviewed for Individual #483 and Individual #595. • The SPCI for Individual #483 described behavioral criteria to be used to determine when restraint should be terminated. • The SPCI for Individual #595 did not include behavioral criteria for determining when restraint should be terminated. A sample of restraint documentation for the 31 physical restraints in the sample was reviewed to determine if the restraint was terminated as soon as the individual was no longer a danger to him/herself or others. • Twenty-seven of 31 (87%) restraints reviewed indicated that the individual was released immediately when no longer a danger by using the action/release code "P". The four checklists that did not meet this criterion, all indicated that the individual was release because staff were unable to maintain the restraint	Noncompliance

#	Provision	Assessment of Status	Compliance
		correctly. • Restraints in the sample lasted from less than one minute to 34 minutes in duration. The facility POI indicated that video review of a sample of restraints showed that some restraints continued when it appeared that the individual was no longer a danger to himself or others. According to the POI, those restraints were reported to DFPS as abuse allegations. Staff involved in those restraints were required to complete refresher training in PMAB. SPCIs should include behavioral indicators for determining when the individual should no longer be considered a danger to himself or others. See section C7 for additional comments regarding the adequacy of SPCIs. The facility was not in substantial compliance with this item.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The facility's policies related to restraint are discussed above with regard to Section C1 of the Settlement Agreement. 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. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • 24 (100%) had current training in RES0105 Restraint Prevention and Rules. • 18 of the 19 (95%) employees who had been employed over 12 months completed RES0105 refresher training within 12 months of the previous training. • 24 (100%) had completed PMAB training within the past twelve months. • 18 of the 19 (95%) employees, who had been employed over 12 months, completed PMAB refresher training within 12 months of previous restraint training. The facility was in substantial compliance with training requirements.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
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 40 restraint records (Sample #C.1), 38 (95%) indicated that restraint was used as a crisis intervention. Two restraints for Individual #406 on 5/12/11 and 5/24/11 indicated that he was given a chemical restraint when he was calm following a behavioral incident. Facility policy did not allow for the use of restraint for reasons other than crisis intervention or medical/dental procedures. The facility had not developed medical desensitization plans for all individuals who required the use of restraint for routine medical care. • 20 individuals were the subject of pretreatment sedation for medical visits in the past six months. • According to a list provided to the monitoring team, none (0%) of these individuals had a medical desensitization plan in place. Although the facility reported to the monitoring team that no individuals had required the use of pretreatment sedation to complete routine dental care, documentation indicated that a number of individuals had refused dental work and would benefit from desensitization programs. • A list provided by MSSLC indicated that Individual #2 and Individual #139 had received pretreatment sedation in the past six months. Neither (0%) had a dental desensitization plan in place. • Dental desensitization programs had been developed for five individuals at the facility. Plans were reviewed for these five individuals (Individual #481, Individual #196, Individual #500, Individual #369, and Individual #456). Each plan included individualized strategies. The dentist for the facility indicated that informal desensitization strategies were being used with a majority of the individuals requiring dental restraints in the past to complete routine exams. These strategies need to be documented in a formalized plan in order to ensure consistent implementation and evaluate progress towards desensitization (also see sections L and Q below). The facility maintained a "Do Not Restrain" list. There were 20 individuals at the facility that had been identified for placement on this list for which restraints would be contraindicated due to medical or physical conditions. • There were a number of individuals at the facility who were listed as being at risk in areas where restraint may have been contraindicated. For example Individual #188, Individual #438, and Individual #597 were at risk for both aspiration and osteoporosis. PSTs should discuss the risk for restraint and make	Noncompliance

#	Provision	Assessment of Status	Compliance
		a determination whether or not restraints are contraindicated PSTs should discuss the need for restraints during medical and dental procedures, and desensitization plans should be developed that include individual specific strategies to try to reduce or eliminate the need for restraint. PST's should also discuss individual's risk factors and determine if and when restraints may be used. Staff should know which individuals are on the "Do Not Restrain" list.	
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	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 35 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 33 out of 35 incidents of restraint (94s%), there was assessment by a restraint monitor. o There was not an assessment by the restraint monitor for restraint incidents in the sample involving Individual #588 (2) or Individual #126 (5). • In 33 out of 33 instances of restraint (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. • In 33 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • In 33 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. Based on a review of 35 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 21 (60%) of the instances of restraint. The exception were: o Individual #483 dated 7/29/11 o Individual #483 dated 8/2/11 o Individual #595 dated 5/23/11 (6 restraints) o Individual #591 dated 5/17/11 o Individual #209 dated 9/9/11 (attempted 3 minutes after release, not attempted a second time) o Individual #588 dated 5/24/11 o Individual #588 dated 7/21/11 o Individual #406 dated 5/12/11 o Individual #385 dated 8/12/11	Noncompliance

#	Provision	Assessment of Status	Compliance
	of monitoring required.	• Monitored and documented vital signs in 21 (60%). • Monitored and documented mental status in 21 (60%). Documentation of monitoring by a health care professional was only provided for two individuals that had been given medical pretreatment sedation. This included Individual #294 dated 8/1/11 and Individual #165 dated 7/19/11. The nurse did not monitor vital signs and mental status every 30 minutes as required in either case. The facility POI indicated restraint checklists were reviewed daily for compliance with C5. Facility audits showed an 80% compliance rate with this provision. The facility was not in substantial compliance with this provision.	
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 38 Restraint Checklists for individuals in non-medical restraint was selected for review for required elements in C6. This included the restraints checklists for sample #C.1. A restraint checklist was not provided for the restraint for Individual #406 on 5/24/11 or Individual #588 on 7/21/11. The following compliance rates were identified for each of the required elements: • In 38 (100%), continuous one-to-one supervision was indicated as having been provided. • In 38 (100%), the date and time restraint was begun were indicated. • In 38 (100%), the location of the restraint was indicated. • In 33 (100%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. The exception was five checklists for Individual #126. This would not have been applicable for those restraints. 19 (56%) indicated what events were occurring that might have led to the behavior (see section C1 for a list of exceptions). • In 38 (100%), the specific reasons for the use of the restraint were indicated. • In 38 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 38 (100%), the names of staff who applied/administered the restraint was recorded. • In 38 (100%) observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In 38 (100%) the date and time the individual was released from restraint were indicated. • In 31 (82%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were recorded. The exceptions were six restraints for Individual #595 on 5/23/11 and the restraint for Individual #385 on 8/12/11. • Restraint documentation reviewed did not indicate that restraints interfered	Noncompliance

#	Provision	Assessment of Status	Compliance
		with mealtimes or that individuals were denied the opportunity to use the toilet. The longest restraint in the sample was 34 minutes in duration. In a sample of 40 records (Sample #C.1), restraint debriefing forms had been completed for 38 (95%). The exceptions were for a restraint involving Individual #406 dated 5/24/11 and Individual #588 dated 7/21/11. The facility's self assessment indicated that the facility was not in compliance with section C6. The monitoring team agrees with this finding. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming. Each individual should be assessed by a nurse for restraint related injuries following restraint. The facility was not in compliance with the requirements of this provision item.	
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:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to MSSLC documentation, during the six-month period prior to the onsite review, a total of 17 individuals were placed in restraint more than three times in a rolling thirty-day period. Eight of these individuals (47%) were reviewed to determine if the requirements of the Settlement Agreement were met (i.e., Individual #483, Individual #595, Individual #365, Individual #491, Individual #153, Individual #31, Individual #591, and Individual #451). PBSPs, safety plans, functional assessments, and personal support plan addendums (PSPAs) following more than three restraints in a rolling thirty-day period were requested for all individuals. • Functional assessments were only available for four (Individual #483, Individual #595, Individual #491, and Individual #591) of these individuals (50%) • PSPAs following more than three restraints in thirty-days were submitted for only four (50%) of the individuals (Individual #595, Individual #365, Individual #153, and Individual #31). Only 50% of the individuals had PSPAs as required, and none of the PSPAs reviewed (0%) reflected an adequate review of the environmental, antecedent, and consequent variables that affected the behaviors that provoked restraint. As suggested in the last report, PSPA meetings should be organized so as to ensure that each of the issues below	Noncompliance

#	Provision	Assessment of Status	Compliance
		are discussed and documented. In order to achieve compliance with this provision item, MSSLC needs to document that each individual's PBSP was implemented with integrity, that specific procedures for training replacement behaviors for behaviors that provokes restraint were developed, and that PBSPs were revised when necessary (i.e., data-based decisions are apparent). Two (Individual #31, and Individual #365's) of the four PSPA minutes reviewed (50%) reflected a discussion of adaptive skills, or biological, medical, or psychosocial factors affecting the behaviors provoking restraints. Individual #31's PSPA indicated that his increase in restraints could be due to a medication change. How this possible medical factor would be more fully assessed or addressed, however, was not reflected in the PSPA. An example of an adequate review of adaptive skills and biological, medical, and or psychosocial factors, on the other hand, was found in Individual #365's PSPA minutes. His PSPA minutes included a discussion of how his hearing loss and poor communication may affect his increase in the behaviors provoking restraint. Further, the PSPA minutes reflected a referral to the speech pathologist for the use of a communication device. 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.	
	(b) review possibly contributing environmental conditions;	One of the four PSPAs reviewed (25%) reflected a discussion of possible contributing environmental factors to the behavior or behaviors provoking restraint. Individual #31's PSPA documented a discussion of how the "…chaotic environment of the home" may affect his increase in the behaviors provoking restraint. The PSPA, however, did not reflect a discussion of how these environmental conditions hypothesized to contribute to his restraints would be addressed. All PSPAs should reflect a discussion of possible contributing environmental factors, and if any are hypothesized to potentially affect dangerous behavior, 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 potential environmental antecedents to the behavior that provoke restraint. Two of the PSPAs reviewed (50%) discussed potential antecedents affecting the behavior provoking restraint. Individual #365's PSPA, for example, indicated that headphones and van rides often led to physical aggression that required restraint. None of the PSPAs reviewed, however, discussed an action plan to eliminate these antecedents, or reduce their effects on the dangerous behavior.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(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 eight individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Eight (100%) were based on the individual's strengths, • Four (50%) specified the objectively defined behavior to be treated that led to the use of the restraint (Individual #153, Individual #31, Individual #591, and Individual #451's definitions of dangerous target behaviors were not operational), • Eight (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 • Eight (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint Three of the eight PBSPs (38%) to weaken or reduce the behaviors that provoked restraint, however, were determined to be inadequate (i.e., Individual #31, Individual #153, and Individual #591) because they did not contain clear, precise interventions based on a functional assessment (see K9). The eight Safety Plans of the individuals in the sample were reviewed. The following represents the results: • In all eight of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In one (12%) of the safety plans reviewed (i.e., Individual #483), 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
	(f) ensure that the individual's	For none of the individuals reviewed (0%) were integrity data available demonstrating	Noncompliance

#	Provision	Assessment of Status	Compliance
	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	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).	
	(g) as necessary, assess and revise the PBSP.	There was no evidence that the PBSPs for any of the individuals reviewed included a discussion of the effectiveness of the current PBSP (including possible modification when necessary) to decrease the future probability of requiring restraint.	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, Daily Incident Management Review Team Meeting meetings, Daily Unit meetings, and Human Rights Committee (HRC) meetings. Restraint incidents were also referred to the PST for follow-up. PSTs met following restraint incidents to review restraints. A sample of Face-to-Face Debriefing and Review Forms related to 33 incidents of non-medical restraint was reviewed by the monitoring team. The review form had an area for signature indicating review by the Unit Director and the Incident Management Team. • In review of 33 restraint review forms for sign off by the Unit Director and IMC Designee, 28 (85%) were reviewed by either the Unit Director and/or the IMC Designee. The exceptions were Individual #483 dated 7/29/11 and 8/7/11, Individual #595 dated 5/31/11, Individual #123 dated 8/31/11, and Individual #331 dated 8/15/11. As noted throughout Section C, restraint documentation contained errors in documentation and monitoring. None of the Restraint Review forms in the sample addressed errors or incorrect procedures in documentation, application, or monitoring of the restraint. The facility needs to document any follow-up to recommendations and actions taken in regards to recommendations that were in the review section of the form. While this was found for the sample of restraints chosen for special review, it did not appear that it was routinely occurring for all restraints. Teams met following restraint incidents but it was not always evident that the team met to consider ways that restraint might be avoided by providing more appropriate supports or programming. For example: • The PST met for Individual #153 following a restraint incident on 8/14/11. He	Noncompliance

#	Provision	Assessment of Status	Compliance
		wanted to move into the community and had been referred by the team for community placement. He had been restrained three times in a 30-day period for aggression towards staff. His aggression was determined to be related to frustration over his assigned living unit and assigned support staff. The team did not consider changes to his environment or support staff. The team agreed to rescind his referral for community placement due to his "recent behaviors." The PSPA further noted that he became upset during the meeting and left when he heard the team's decision. It was noted during observation of a daily unit meeting and Daily Incident Review Team meeting that circumstance of restraints was reviewed by both teams and recommendations were made regarding the restraint incident. Documentation was reviewed for accuracy. The facility did not have a system in place to document follow-up to any recommendations made in committee meetings. Additionally, the facility had begun reviewing a sample of restraints on video surveillance tape. The facility maintained a Special Review Tracking Log to document the result of restraint videos reviewed. Several instances were noted where staff were required to attend refresher training in PMAB techniques following review of the restraint. Review of restraint incidents by video was a good idea and should be an effective training tool for staff involved in restraint incidents. It was evident that the facility had a review process in place. In order to ensure that adequate review is occurring for all restraints, the IMC and Director/Designee need to document any findings, recommendations, and/or corrective action taken and sign off on restraint documentation.	

Recommendations:

1. 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 (C1).

2. The facility needs to address environmental issues that contribute to a high number of behavioral incidents at the facility (C1).

3. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming (C1, C2, C6).

4. Accurately document behavioral indicators used to determine when individuals were released from restraints (C2).

5. PSTs should discuss the need for restraints during medical and dental procedures and desensitization plans should be developed to try to reduce or eliminate the need for restraint (C4).

6. PST's should discuss individual's risk factors and determine if and when restraints may be used. Staff should know which individuals are on the "Do Not Restrain" list (C4).

7. When restraints are not applied, monitored, or documented correctly, the restraint monitor should include this information in the follow-up assessment (C8).

8. Develop a plan of correction to address any problems noted in the review of restraints (C8).

9. The IMC and Director/Designee need to document any findings, recommendations, and/or corrective action taken and sign off on all restraint documentation (C8).

10. Complete all of the requirements for provision item C7 (C7).

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 Section D Presentation Book o DADS Policy: Incident Management #002.2,dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o MSSLC Policy: Client Management – Abuse and Neglect dated 8/25/11 o MSSLC Policy: Client Management – Client Injuries dated 8/30/11 o MSSLC Policy: Client Management- Facility Incident Management dated 8/25/11 o Information used to educate individuals and LARs on identifying and reporting unusual incidents. o Incident Management Committee meeting minutes for each Monday of the past six months o Sample of Unit Level Meeting minutes o MSSLC Plan of Improvement o MSSLC Chronic Caller List o Three most recent five-day status reports o Training transcripts 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Acknowledgement to report abuse for all employees hired in the past two months (97) o Training and background checks for the last three employees hired o Training transcripts for facility investigators o Training transcripts for DFPS investigators assigned to complete investigations at MSSLC o Abuse/Neglect/Exploitation Trend Reports FY11 o Injury Trend Reports FY11 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 terminated based on background checks o A sample of acknowledgement to self report criminal activity for 24 current employees o Injury reports for three most recent incidents of peer-to-peer aggression incidents (Individual #491, Individual #497, and Individual #2) o BSP and PSPA related to the last three incidents of peer-to-peer aggression o List of all serious injuries for the past six months o List of Injuries by individual since 2/1/11 o List of all A/N/E allegations since 2/1/11 including case disposition o List of all confirmed allegations of abuse and neglect o List of employees reassigned due to ANE allegations o A sample of completed audits for abuse and neglect concerns or unusual incidents o Documentation of employee disciplinary action taken with regard to DFPS case #40008087,

DFPS case #39316192, DPFS case #39438467, UIR #110601, UIR #110619, UIR #110623

- Injury reports for the past six months for Individual #494, Individual #99, Individual #233, Individual #361, Individual #202, Individual #425, Individual #365, and Individual #331.
- Documentation from the following completed investigations including follow-up:

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#39253527	Neglect (1) Physical Abuse (3)	Confirmed (1) Confirmed (1) Unconfirmed (2)	5/3/11 4:00 pm	5/5/11 7:20 am	5/23/11
#39222987	Physical Abuse (2)	Inconclusive (1) Confirmed (1)	5/1/11 8:42 am	5/3/11 1:30 pm	5/19/11
#38932027	Physical Abuse	Confirmed	4/5/11 11:00 am	4/6/11 8:16 am	4/25/11
#38917707	Physical Abuse	Confirmed	4/3/11 11:18 pm	4/4/11 9:53 am	4/20/11
#38874197	Neglect (8)	Confirmed (8)	3/30/11 3:19 pm	3/31/11 1:50 pm	4/18/11
#40008087	Physical Abuse (1)	Unconfirmed (1)	6/30/11 1:50 pm	7/2/11 2:24 pm	7/14/11
#39938330	Neglect (1)	Unconfirmed (1)	6/24/11 4:46 pm	6/25/11 5:00 pm	6/29/11
#39816192	Neglect (1)	Confirmed (1)	6/15/11 10:13 pm	6/16/11 12:36 pm	7/5/11
#39823348	Physical Abuse (1)	Unconfirmed (1)	6/16/11 12:44 pm	6/17/11 8:01 am	6/23/11
#39438467	Neglect (2)	Unconfirmed (1) Confirmed (1)	5/17/11 3:23 pm	5/17/11 6:00 pm	6/14/11
#40249730	Emotional/Verbal Abuse (5)	Unconfirmed (5)	8/25/11 9:44 am	8/28/11 3:50 pm	9/4/11
#39908009	Physical Abuse (4)	Unconfirmed (4)	6/22/11 10:37 pm	6/24/11 3:15 pm	7/12/11
#39938671	Physical Abuse (1)	Unconfirmed (1)	6/24/11 5:24 pm	6/26/11 7:10 am	7/14/11
#39634167	Physical Abuse (1)	Confirmed (1)	6/1/11 4:09 pm	6/2/11 3:00 pm	6/22/11
#40214315	Physical Abuse (2)	Confirmed (1) Unconfirmed (1)	7/25/11 6:15 pm	7/26/11 1:15 pm	8/12/11
#40202668	Neglect (1) Physical Abuse(1)	Unconfirmed (1) Unconfirmed (1)	7/16/11 2:45 pm	7/16/11 3:12 pm	7/21/11

#40038808	Emotional /Verbal Abuse (2)	Unfounded (2)	7/4/11 1:28 pm	7/5/11 2:45 pm	7/7/11
#40112907	Physical Abuse (1)	Unfounded (1)	7/9/11 9:32 pm	7/10/11 8:45 am	7/19/11
#40032687	Sexual Abuse (1) Emotional/Verbal Abuse (1)	Unfounded (2)	7/2/11 2:16 pm	7/2/11 4:33 pm	7/12/11
#40043127	Neglect (1) Physical Abuse(1)	Unconfirmed (2)	7/5/11 9:31 am	7/5/11 3:28 pm	7/13/11
Sample D.2	**Type of Incident**	**DFPS Disposition**	**Date of DFPS Referral**	**Began Investigation**	**Closed Investigation**
#40250694	Emotional Abuse	Referred Back	8/25/11 5:51 pm	Unknown	9/2/11
#40077989	Neglect	Referred Back	7/7/11 10:14 am	7/7/11 4:15 pm	7/14/11
#40232057	Emotional Abuse	Referred Back	8/10/11 9:24 am	Unknown	8/17/11
#39911907	Emotional Abuse	Referred Back	6/23/11 10:56 am	Unknown	7/1/11
Sample D.3	**Type of Incident**	**Date/Time of Incident**			
#110813	Serious Injury	8/13/11 12:15 pm			
#110524	Serious Injury	5/23/11 8:00 pm			
#110815	Serious Injury	8/15/11 4:01 pm			
#110813	Serious Injury	8/13/11 12:35 pm			

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
- Terri Moon, Human Rights Officer
- Charles Bratcher, Quality Services Director
- 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 9/19/11 o Longhorn Daily Unit Meeting 9/21/11 o Restraint Reduction Committee Meeting 9/22/11 o Human Rights Committee Meeting 9/20/11 o PSPA meeting for Individual #37 o Annual PSP meetings for Individual #360 and Individual #123
	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. The facility's POI for section D indicated that several new policies and processes had been implemented to address problems noted in the last monitoring report. A list of actions taken by the facility to address problems is discussed further in the Section D summary section below. The POI indicated that the facility had implemented an audit system to address compliance with section D. The POI did not indicate how the findings from this new audit process were used to determine the self-rating of each provision item. The facility POI indicated that MSSLC was in substantial compliance with all items in section D of the Settlement Agreement, except sections D3e. The monitoring team found that 18 out of 22 areas of section D were in substantial compliance. As discussed below, the monitoring did not find evidence to support substantial compliance with provisions D3b, D3e, D3f, or D3g. The facility POI noted processes that were in place to address provisions, but did not indicate if those processes were audited for effectiveness. The facility did not appear to have a quality improvement process in place to address issues identified through the self-audit system. The facility was holding daily unit meetings to review all incidents and injuries. Observation of these meetings indicated that this was an effective process for ensuring that incidents were reviewed and appropriate recommendations were made regarding specific incidents. The facility will need to implement a process to address incident and injury trends.
	Summary of Monitor's Assessment: According to information provided to the monitoring team, investigation of 818 allegation of abuse, neglect, or exploitation were conducted by DFPS at the facility in the past six months. Of these 818 allegations, 27 (3%) were confirmed allegations by DFPS (including 10 allegations of physical abuse, one allegation of emotional/verbal abuse, and 16 allegations of neglect), 326 (40%) were unconfirmed allegations, 10 (1%) were inconclusive, 129 (16%) were referred back to the facility because they did not meet the DFPS

	definition of abuse or neglect, and 324 (40%) were unfounded. There were an additional 73 serious incidents at the facility that did not involve allegations of abuse or neglect included in trend reports for last six months. These incidents were investigated by the facility investigators. There were a total of 1590 injuries reported between 2/1/11 and 7/31/11. This was an increase from the 1478 injuries reported in the six previous months. These 1590 injuries included 25 serious injuries resulting in fractures or sutures. The facility needs to further explore trends of incidents and injuries at the facility and develop a plan of action to address any trends identified in order to reduce the significant number of injuries occurring at the facility. Consideration should be given to factors that generally contribute to injuries and incidents at a large facility, such as crowded living areas, inappropriate levels of supervision, and lack of meaningful activities. Individuals involved in incidents were generally assigned one-to-one supervision to try to reduce the occurrence of incidents. It was noted during observations at the facility that one-to-one supervision was not being used to effectively address incidents and often increased the likelihood that additional incidents may occur. One-to-one staff was not adequately trained to engage individuals in meaningful activities and address behavioral incidence in a non-threatening manner. Numerous incidents were documented where individuals displayed increased aggression related to being placed on a heightened level of supervision. A number of confirmed allegations of abuse and neglect occurred during behavior incidents that escalated when staff did not use appropriate intervention strategies. Interagency meetings continued to be held quarterly with MSSLC, DFPS, and OIG administrative personnel to address systemic issues. As noted in section D3e below, investigations completed by DFPS still did not always commence within 24 hours of the initial report as required by the Settlement Agreement and were not always completed within 10 days. The interagency committee had developed action steps to try to minimize the length of investigations and support better cooperation among investigative agencies. Interagency meetings with DFPS, OIG, and the facility were a positive step towards resolving issues regarding outside investigations. Steps taken to work towards substantial compliance included: • The facility Abuse and Neglect Policy was revised to address reporting and timeline requirements. • The facility had developed a checklist for OIG document requests. • Facility staff was in serviced on reporting injuries. • DADS had developed an extension request form for internal investigations. • DFPS had added an electronic signature for supervisors to use indicating review of investigations. • A new format was implemented as of 8/2/11 for tracking and trending data. • Posters were created with contact information for the new Human Resource Officer. • A process was developed for auditing individual records to determine if injuries were reported for investigation when warranted.

	MSSLC continued to consistently investigate all allegations and incidents. As was noted in the last monitoring report, the facility had a good system in place for dealing with the massive number of incidents and investigations. Behavioral issues continued to be the underlying cause for a majority of the incidents and injuries that occurred at the facility. The facility, however, had little success in reducing the number of behavioral incidents leading to incidents and injuries. It remains a concern of the monitoring team that individuals at the facility were at high risk for harm in their current environment. As the facility moves forward, all departments will need to take an integrated, aggressive approach to restructuring the environment, supports, and programming to address these issues.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require 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. The facility policy stated that failure of an employee to report an allegation of abuse, neglect, or exploitation to DFPS within the allotted time period without sufficient justification was considered a violation of the agency's policy and made the employee subject to disciplinary action and possible criminal prosecution. 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 with both information on identifying abuse and neglect and steps to be taken if abuse or neglect was either suspected or witnessed. • 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 by calling the 800#. All staff wore badges that contained reporting information on the back. • Employees at MSSLC were required to sign a form titled Acknowledgement of Responsibility for Reporting Abuse/Neglect Incident(s) form during pre-service training and every 12 months thereafter. Completed forms were requested by the monitoring team for a random sample of 24 employees. All (100%) had signed a form acknowledging responsibility to report abuse and neglect within the past 12 months. Additionally, signed forms were provided for all employees	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		hired within the past two months. The facility provided a copy of the signed acknowledgement for 97 new employees. • 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. • A review of cases reported to DFPS indicated that staff routinely report cases of suspected abuse and neglect to DFPS for investigation. Documentation of disciplinary action was reviewed for six cases in which the facility, DFPS, or OIG substantiated an allegation of abuse or neglect. In all six cases, timely disciplinary action was taken for all employees involved in confirmed allegations. • For DFPS case #40008087, DFPS did not confirm an allegation of physical abuse by a nurse. The facility did confirm the allegation of physical abuse after reviewing all evidence. According to the facility UIR, the finding was sent to the Texas Medical/Nursing Board for appropriate disciplinary action. • For DFPS case #39816192, an employee received a five-day suspension following a confirmed allegation of neglect where an individual's one to one supervision was breached. • For DFPS case #39438467, an employee was terminated following a confirmation of neglect. In this case, staff failed to provide appropriate support when transferring an individual resulting in a fractured leg. • UIR #110601 involved a physical abuse allegation investigated by DFPS and OIG. DFPS found the allegation to be inconclusive, while OIG found evidence of criminal activity. The alleged perpetrator was terminated. • UIR #110619 involved a confirmed allegation of emotional/verbal abuse. The alleged perpetrator was dismissed following the outcome of the case. • UIR #110623 involved a confirmed allegation of neglect on 6/23/11. Notice of pending disciplinary action was approved by the facility on 7/14/11 and the employee was terminated on 7/28/11. The facility was found to be in substantial 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		

#	Provision	Assessment of Status	Compliance
	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 official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	According to DADS Protection From Harm – Abuse, Neglect, and Exploitation Policy, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. This was consistent with the requirements of the Settlement Agreement. With regard to serious incidents, the facility policy addressing Incident Management required that all serious incidents be reported to the facility director within one hour, reported to DFPS immediately 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. It further specified requirements for reporting certain types of incidents to other outside agencies. This policy was consistent with the requirements of the Settlement Agreement. According to a list of abuse, neglect, and exploitation investigations provided to the monitoring team, investigation of 818 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility since the last monitoring visit. From these 818 allegations, there were: • 294 allegations of physical abuse, o 10 were substantiated, o 143 were unsubstantiated, o 111 were unfounded o 4 were inconclusive, and o 25 were referred back to the facility for investigation. • 143 allegation of verbal/emotional abuse, o 1 was substantiated, o 56 were unsubstantiated, o 47 were unfounded o 1 were inconclusive, and o 38 were referred back to the facility for investigation. • 175 allegations of sexual abuse o 33 were unsubstantiated, o 135 were unfounded, and o 7 were referred back to the facility for investigation. • 197 allegations of neglect, o 16 were substantiated, o 93 were unsubstantiated, o 2 were inconclusive, o 27 were unfounded, and o 59 were referred back to the facility for investigation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance

		• 9 allegation of exploitation.
		  o None were substantiated,
		  o 1 was unsubstantiated,
		  o 3 were inconclusive, and
		  o 4 were unfounded.
		
		According to the FY11 Trend Report, the facility investigators conducted investigations for 73 additional serious incidents from 2/1/11 to 7/31/11. The incidents included:
		• Choking – 6
		• Encounter with law enforcement - 4
		• Serious Injuries, peer to peer aggression – 2
		• Serious Injuries, determined cause – 21
		• Serious Injuries, undetermined cause – 2
		• Sexual Incidents – 9
		• Suicide Threat - 5
		• Unauthorized Departures – 1
		• Deaths – 2
		• Other (incident type not listed) – 21
		
		A sample of eight serious injuries was reviewed for compliance with D2i. All serious injuries in the sample reviewed were investigated by the facility.
		
		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. All staff wore name badges with reporting procedures on the back of the badge.
		
		From the investigations since 3/1/11 reported by the facility, 28 investigations were selected for review. The 28 comprised three samples of investigations:
		• Sample #D.1 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 included a sample of facility investigations that had been referred to the facility by DFPS for further investigation.
		• Sample #D.3 included investigations the facility completed related to serious incidents and other serious incidents not reportable to DFPS.
		
		Based on a review of the 20 investigative reports included in Sample #D.1:
		• 19 of 20 (95 %) reports in the sample indicated that DFPS was notified within one hour of the incident or discovery of the incident.	

#	Provision	Assessment of Status	Compliance
		o DFPS Case #40202668 was reported to DFPS at 2:48 pm on 7/16/11. Integrated progress notes indicated that security informed a nurse of the allegation at 8:41 am on 7/16/11. • Twenty (100%) indicated, the facility director or designee was notified within one hour. • Twenty (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy. In reviewing Sample D.3 (serious incidents), three of four (75%) were reported immediately (within one hour) to the facility director/designee. The facility director was not notified within one hour in the following incidents: • Individual #514 had an encounter with law enforcement. The director was not informed of the incident until the following day. The facility had a standardized reporting format. The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents other than abuse and neglect. This form was adequate for recording information on the incident, follow-up, and review. A standardized UIR which contained information about notifications was included in: • 20 out of 20 (100%) investigation files in Sample #D.1. • Eight of eight (100%) investigation files in Sample #D.2 and Sample #D.3. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. All employees signed an acknowledgement form annually. A sample of this form was requested for 97 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in the sample had signed this form. The facility had implemented new procedures for reporting serious injuries for investigation. Physicians were now required to report all serious injuries to Security Camera Monitors within one hour of determination. The monitors were responsible for immediately reporting serious injuries of unknown cause or injuries that may have resulted from abuse or neglect to DFPS. All other serious injuries were to be reported to facility investigators. The facility was in substantial compliance with this provision.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect,	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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	The facility did have a system in place for assuring that alleged perpetrators were removed from regular duty until notification was made by the facility Incident Management Coordinator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of employment. Based on a review of 20 investigation reports included in Sample D.1, in every instance where an alleged perpetrator (AP) was known, the AP was immediately placed in no contact status. Additionally, the monitoring team was provided with a log of employees who had been reassigned since 3/9/11. The log included the applicable investigation case number, the date of the incident and the date the employee was returned to work if the employee was not discharged or had resigned. Review of 20 investigation files included in Sample D.1 showed there were no instances where staff that had been removed from direct contact and subsequently reinstated after a well-supported preliminary assessment posed a risk to individuals or the integrity of the investigation. Based on a review of the 20 investigation files in Sample D.1, there was clear documentation that adequate additional action was taken to protect individuals in each case. Additional actions that might have been taken in regard to changes in level of supervision, repairs to physical property, or additional medical monitoring were documented in facility UIRs. The facility maintained a "chronic caller list" of individuals with a history of making spurious allegations of abuse or neglect. Twenty individuals were on this list. Investigations involving at least some of these individuals were included in the sample of investigations reviewed. Immediate protections including removing APs from direct contact were documented in each case until a streamlined investigation had been completed. The facility POI indicated that the facility was in substantial compliance with this item. The monitoring team agreed with this rating.	
	(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	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. Documentation of training was kept by the facility and a sample of 24 staff training transcripts was reviewed (Sample #C.2). A review of the training curricula related to	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	completion of such training.	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: • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 18 (95%) of 19 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. • 24 (100%) employees had completed competency-based training on unusual incidents (UNU0100) refresher training within the past 12 months. • Six (32%) of the 19 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. Based on interviews with eight direct support staff in various homes and day programs: • Eight (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The facility POI indicated that the following procedures had been put into place to ensure all staff received timely training on recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. • All staff were scheduled to complete training in the 11th anniversary month of employment with corresponding notice given to the staff member's supervisor. • Supervisors were notified when staff did not complete scheduled training and training was rescheduled. • Any staff member failing to attend or successfully complete training was deemed no longer meeting the qualifications for his/her position and referred to the department director for appropriate action, including removal from his/her position until training was completed. The facility provided evidence that this was occurring. The training department sent notification by email to department heads indicated that staff who had not completed training as required should be removed from direct contact with individuals immediately. The facility was rated as being in substantial compliance with this provision.	
	(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	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter. A sample of this form was requested for 97 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	the sample had signed this form. 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 sample of DPFS reports included one example where an employee failed to report abuse and the facility took action. In DFPS case #38917707, an employee received disciplinary action for failing to report abuse. The facility was in substantial compliance with this item.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	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 clear easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. MSSLC Policies and Procedures Manual, Client Management – Personal Support Plan Process included a checklist to be used at annual PST meetings. There was a checklist item for providing information to individuals regarding abuse, neglect, and exploitation. The QMRP was responsible for monitoring the checklist. This information was shared with individuals at the annual PST meetings observed by the monitoring team. In interviewing a sample of eight individuals, all eight (100%) said that they would tell a staff person if someone hurt them or they saw someone being hurt. Four of the individuals questioned were able to identify the DFPS abuse, neglect, and exploitation hot line number. The facility was in substantial compliance with this item.	Substantial Compliance
	(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.	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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Observations by the monitoring team of all living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was a human rights officer at the facility. Information was posted around campus identifying the rights officer with her name, picture, and contact information. The rights officer was known by individuals at the facility and was actively involved in meetings regarding abuse, neglect, and rights issues. 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.	Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications. Based on a review of 20 allegation investigations completed by DFPS (Sample #D.1), DFPS had notified law enforcement and OIG of the allegation in 20 (100%). Not all allegations were necessarily reportable to OIG, but a referral was made in each investigation. OIG found evidence of criminal activity in four of the cases in the sample. The facility had a process in place to verify that law enforcement had been notified when appropriate. Facility UIRs documented notification to law enforcement and the outcome of the investigation if an investigation was completed by OIG. 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	According to MSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, 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. The facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who in good	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	manner.	faith had reported an allegation of abuse/neglect/exploitation. No names were provided. Based on a review of investigation records (Sample #D.1), there were concerns noted related to potential retaliation by coworkers in DFPS investigation #39634167. The facility letter of disciplinary action addressed the retaliation and the staff person involved was terminated. It was evident based on the sample reviewed, staff routinely reported incidents when abuse or neglect was suspected. Additionally, the facility's policy addressing reporting of abuse, neglect, and exploitation had been revised to include provisions to ensure staffs were required to report all allegations first to the DFPS hotline, then to their supervisor with the provision that not reporting to a supervisor to preserve anonymity was not a disciplinary issue. The facility rated itself in substantial compliance with this item. The monitoring team agrees with that assessment. The facility was in substantial compliance with this item.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The facility had a monitoring process in place to review a sample of individual records, including nursing notes, observation notes, and progress notes to identify annotations that should have resulted in an injury report. These audits were being completed on a sample of individuals monthly. Sample #D.3 included investigations completed on a sample of serious injuries. These investigations appeared to be routine for all serious injuries whether the cause was determined or unknown. The Incident Management Review Team selected individuals with a high number of injuries each week to discuss action that could be taken to reduce injuries for that individual. Action steps were documented for follow-up. For example, the team discussed a trend of injuries for Individual #225 over a five-month period. He had 55 non-serious injuries and two serious injuries during the period reviewed. The team determined that most of the injuries were due to self-injurious behaviors (SIB). The team held an in-depth discussion regarding when the SIB was occurring. The individual wanted to move to another facility to be closer to his grandmother. The team recommended planning more frequent trips to see his grandmother, completing a referral for a transfer to a facility closer to his family, and offering him more time outside. Additionally, a sample of injury reports was reviewed for non-serious discovered injuries and serious witnessed or discovered injuries for Individual #494, Individual #99, Individual #233, Individual #361, Individual #202, Individual #425, Individual #365, and Individual #331. These individuals were randomly chosen from a list of individuals who had sustained a serious injury in the past six months. The following is a summary of that	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		review. • Individual #494- o 2/22/11 non-serious - facility investigated o 3/2/11 non-serious – facility investigated o 6/11/11 serious – facility investigated o 6/15/11 serious – facility investigated o 6/20/11 non-serious – no investigation • Individual #99 - o 2/19/11 non-serious – facility investigated o 3/31/11 serious – facility investigated o 4/6/11 non-serious – facility investigated o 4/23/11 serious – facility investigated • Individual #233 o 4/9/11 serious injury – facility investigated. • Individual #361- o 2/10/11 non-serious – facility investigated o 3/19/11 serious – facility investigated • Individual #202 o 3/9/11 non serious – facility investigated o 4/4/11 serious – facility investigated o 5/28/11 non-serious – facility investigated o 5/31/11 non-serious – no investigation o 6/1/11 serious – facility investigated • Individual #331 o 3/7/11 – non-serious – no investigation o 3/9/11 – non-serious – DFPS investigated o 6/1/11 – non-serious – no investigation o 8/11/11 – non-serious – DFPS investigated • Individual #365 o 3/9/11 – non-serious – facility investigated o 4/13/11 – non-serious – facility investigated o 5/30/11 – non-serious – no investigation o 5/31/11 – non-serious – facility investigated o 7/13/11 – non-serious – no investigation o 7/26/11 – serious – facility investigated • Individual #425 o 5/26/11 – serious – facility investigated For 22 of 28 injuries in the sample that were either discovered (with unknown cause) and/or deemed serious, the facility had conducted an investigation to try to determine	

#	Provision	Assessment of Status	Compliance
		the cause of the injury. Five of the injuries not investigated were non-suspicious minor injuries and the sixth (Individual #331 on 3/7/11) occurred away from the facility. Client Injury Assessment forms were completed for all injuries in the sample. A sample of Daily Incident Management Review Team (IMRT) meeting minutes since the last monitoring review were reviewed and indicated that injuries of both known and unknown cause were routinely reviewed by the committee. Observation of both the Daily Unit Meeting and Daily Incident Management Review Team meeting during the monitoring visit confirmed that injuries were reviewed by both teams and follow-up recommendations were made when warranted. The POI rated this section as being in substantial compliance. The monitoring team agreed with this compliance rating.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such 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 DADS Incident Management Policy • described a comprehensive manner of the conduct of all such investigations • addressed training requirements for investigators including training in working with people with developmental disabilities 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. According to an overview of training provided by DFPS, this included training on 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 investigators (100%) had completed the requirements for investigations training. • Eleven DFPS investigators (100%) had completed the requirements for training	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		regarding individuals with developmental disabilities. MSSLC had six employees designated to complete investigations. The training records for facility investigators were reviewed with the following results: • Six (100%) facility investigators had completed CIT0100 Comprehensive Investigator Training. Two campus coordinators had not completed this course; • Six (100%) had completed UNU011 Unusual Incidents within the past 12 months; • Six (100%) had completed Root Cause Analysis according to training transcripts reviewed. Seven of the Campus Coordinators had not completed this course; and • Six (100%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. Additionally, facility investigators did not have supervisory duties, therefore, they would not be within the direct line of supervision of the alleged perpetrator. The facility was in substantial compliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	A sample of investigations was reviewed for indication of cooperation by facility staff with outside investigators. Twelve (60%) of 20 investigations were not completed within 10 days by DFPS investigators. All twelve indicated that additional time was needed to complete the investigative process including interviewing witnesses. The Incident Management Coordinator reported that the facility had a cooperative relationship with both DFPS and OIG. The three agencies were meeting quarterly to discuss any problems encountered in the investigative process. Minutes from the 8/11/11 quarterly meeting indicated that there were some barriers to completing investigations. OIG and DFPS reported: • Confusion and difficulty in locating and talking to witnesses assigned to APAC, including absences and incorrect phone numbers, • Problems in locating collateral witnesses and making contact to obtain witness statements, • Acquiring video footage as evidence, and • Receiving needed documentation in a timely manner. The Incident Management Coordinator had developed a plan of action to address problems noted. The monitoring team will review results of corrective action during the next monitoring visit.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The monitoring team found the facility not in substantial compliance with this item.	
	(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 20 investigations completed by DFPS (Sample #D.1), 20 had been referred to law enforcement agencies. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • OIG found criminal evidence of criminal activity in four cases in the sample. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. As noted in D3b, OIG had requested that the facility have documentation ready for them when they arrive for investigations. The facility was now using a checklist to prepare documents for OIG. The facility was found to be in substantial compliance with this provision.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The MSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to collect and secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. 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. The facility remained in substantial compliance with this item.	Substantial compliance

#	Provision	Assessment of Status	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 included timelines for investigations. The facility had taken steps to comply with this provision: • The facility policy had been revised to include clearer mandates that investigations were to be completed within required timelines. • A meeting was held with DFPS to address investigation timelines on 5/31/11. • New DFPS commencement policy was incorporated into facility policy. • Security Camera Operations was designated as the primary contact and evidence repository for DFPS investigations. 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 and #D.3) 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: • DFPS reports did not describe substantive investigatory tasks that were undertaken within the first 24 hours in six out of 20 investigations (30%) in Sample #D.1. DFPS was in the process of modifying standard operating procedures regarding the conduct and documentation of actions taken to commence an investigation. This included investigation #39908009, #39938671, #40038808, #40008087, #39938330, and #39816192. • Investigations noted the date and time of initial contact with the alleged victim. This contact did not occur within 24 hours in nine of 20 (45%) investigations. This included investigation #39908009, #, #39938671, #40038808, #40008087, #39938330, #39253527, #39222987, #40249730, and #39816192. Again, the new DFPS reporting of actions to commence each investigation are likely to indicate what other activities were conducted and whether face to face contact with the alleged victim occurred. • Nine of 20 (45%) were completed within 10 calendar days of the incident. o Extensions were filed in all 11 cases that were not completed within 10 days. All extensions were filed either due to additional witnesses needed to be interviewed or additional evidence needed to be gathered, though what led to the delay in gathering evidence or obtaining witness statements in any of the cases reviewed was not included. • All 20 (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 11 of the 20 DFPS investigations reviewed (55%), concerns or	Noncompliance

#	Provision	Assessment of Status	Compliance
		recommendations for corrective action were included. These concerns were referred back to the facility to address. In most cases concerns noted were adequate and appropriate. o For DFPS case #38932027 regarding a confirmed allegation of physical abuse, the investigator noted, "It is a concern that any staff would physically put their hands on an individual." She further noted in regards to another individual that was present during the incident, "it is also a concern for Individual #431 that during this altercation he may have been hurt." o For DPFS case #40008087, the allegation occurred during a behavioral incident where staff did not follow the individual's BSP. The BSP was reviewed as evidence and staff response to his behavior was used as evidence. The investigator failed to note a concern regarding failure of staff to provide appropriate support by using interventions in the BSP. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3 : • One out of four (25%) of the UIRs reviewed indicated when the investigation commenced. The UIR indicated when the incident was reported and what action was taken by the investigator, but did not include a time and date for the action taken (e.g., the UIR did not note the time witness was interviewed). UIR #110815 gave the time and date for investigative tasks. • Three of four (75%) indicated that the investigator completed a report within 10 days of notification of the incident. The exception was UIR #110813. It was completed in 11 days. • Four (100%) of the investigations completed in the sample indicated that the facility director and incident management coordinator had reviewed the report immediately upon completion. • In four investigations reviewed, recommendation for corrective action was included in one of the investigations (25%). Investigation should include follow-up recommendations regarding medical care, changes in levels of supervision, or behavioral interventions that might prevent a similar incident from occurring in the future. The facility needs to ensure that documentation reflects the time and date of investigative activities. The facility's action plan for addressing compliance with section D indicated that investigators have recently been trained to document the time and date that investigative tasks are completed on the UIR. This was a repeat finding from the last	

#	Provision	Assessment of Status	Compliance
		monitoring visit. Documentation for DFPS investigations did not support that investigations commenced within 24 hours in most cases, nor was it adequate to support that extensions were only approved due to extraordinary circumstances. 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 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.	MSSLC Incident Management Policy required a UIR to 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 and #D.3) were reviewed. The results of these reviews are discussed in detail below; 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: • For the investigations in Sample #D.1, the report utilized a standardized format that set forth explicitly and separately, the following: o In 20 (100%), each serious incident or allegations of wrongdoing; o In 20 (100%), the name(s) of all witnesses; o In 20 (100%), the name(s) of all alleged victims and perpetrators (when known); o In 20 (100%), the names of all persons interviewed during the investigation; o In 20 (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 20 (100%), all documents reviewed during the investigation; o In 20 (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. DFPS investigations now included a statement indicating that previous investigations were reviewed and either found relevant or not relevant to the case. o All DFPS reports included the statement: "The prior case history of principals was reviewed and not used in the current case because it was deemed not relevant." It was not clear why the allegation history of alleged victim and/or perpetrator was deemed not relevant in some cases. For example: ▪ There was a history of similar allegations made against both APs in DFPS Case #40202668. According to the DPFS	Noncompliance

#	Provision	Assessment of Status	Compliance
		investigation, these allegations were not deemed relevant. o In 20 (100%), the investigator's findings; and o In 20 (100%), the investigator's reasons for his/her conclusions. Although investigations were documented in a consistent format, there was not always clear evidence that conclusions were based on the documented evidence. For example: • In DFPS Case #40202668, the alleged victim accused staff on duty of hitting him in the face. His face was swollen. The doctor documented that swelling was likely to be a side effect of a new medication that he had taken. DFPS only interviewed the alleged victim and alleged perpetrators. No additional witnesses were named. Other staff were on duty at the time of the incident. DFPS determined that the allegation was unconfirmed though there was not enough evidence to rule out the allegation. • In DFPS case #39634167, DFPS found the allegation to be inconclusive based on the evidence. The facility reviewed the evidence and confirmed the allegation. OIG reviewed the same evidence and found evidence of criminal activity. As a result, the local DFPS office reported it will be re-opening this investigation. <u>Facility Investigations</u> The following summarizes the results of the review of eight facility investigations included in sample #D.2 and #D.3 • The report utilized a standardized format that set forth explicitly and separately, the following: o In eight (100%), each serious incident or allegations of wrongdoing; o In eight (100%), the name(s) of all witnesses; o In eight (100%), the name(s) of all alleged victims and perpetrators when known; o In eight (100%), the names of all persons interviewed during the investigation; o In eight (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 eight (100%), all documents reviewed during the investigation; o In eight (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 eight (100%), the investigator's findings; and o In eight (100%), the investigator's reasons for his/her conclusions. While the facility rated itself in substantial compliance with this provision, the	

#	Provision	Assessment of Status	Compliance
		monitoring team did not find the facility to be meeting this requirement. With regard to the DFPS investigations, the issue identified was related to reports not including a description of the results of a review conducted of previous cases involving the alleged perpetrator and/or victim. While a blanket statement was now included in each investigation stating that prior allegations were not relevant, real consideration did not appear to be given when there was a history of similar allegations. Additionally, DFPS needs ensure a clear link is provided between evidence reviewed and findings.	
	(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.	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 20 DFPS investigations included in Sample #D.1: • In 19 investigative files reviewed (95%), there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. DFPS case #38874197 indicated that it had been submitted to the DFPS supervisor, but there was no indication that it had been approved. • UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and Director of Facility. Twenty (100%) DFPS investigations were reviewed by the facility director, and IMC following completion. o Fourteen (70%) were reviewed by the Facility Director and Incident Management Coordinator within five days of receipt of the completed investigation. Exceptions included: ▪ DFPS #39634167 – reviewed 8 days after completion, ▪ DFPS #40202668 – reviewed 7 days after completion, ▪ DFPS #39222987 – reviewed 8 days after completion, ▪ DFPS #38932027 – reviewed 10 days after completion, ▪ DFPS #38917707 – reviewed 15 days after completion, ▪ DFPS #39938330 – reviewed 6 days after completion, o Three of the completed reviews included additional recommendations or comments by the facility director or IMC. • DFPS noted concerns or made recommendations in 11 (55%) of the cases in sample #D.1. The facility documented follow-up to all recommendations made by DFPS in all 11 cases. Additional investigations were reviewed for this requirement below in regards to	Noncompliance

#	Provision	Assessment of Status	Compliance
		investigations completed by the facility. <u>Facility Investigations</u> • In eight of eight (100%) UIRs from sample #D.2 and #D.3 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon completion. Recommendations for follow-up were made in three of the five investigations completed by the facility. The facility needs to ensure that all investigations are reviewed in a timely manner to ensure swift follow-up action when indicated.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A uniform UIR was completed for each unusual incident in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form. Evidence of follow-up to recommendations was included in the investigation file.	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.	The facility had developed a data base to track follow-up on recommendations from investigations. In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included was selected for review. This subsample was comprised of the following investigations: DFPS Case #38917707, DFPS Case #39908009, DFPS Case ##39634167, DFPS Case ##39634167, and DFPS Case #39911907. Documentation of follow-up action was included in all investigations in the sample reviewed. Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations. The following summarizes the results of this review: • The facility documented disciplinary action that was taken in regards to confirmed cases of abuse or neglect in the sample. • DFPS Case #38917707 confirmed one allegations of physical abuse against one staff. According to the UIR completed on the incident, immediate action was taken to ensure the health and safety of the individual involved in the incident. DFPS completed the investigation on 4/20/11. Disciplinary action resulting in termination was initiated on 5/6/11. The facility UIR included recommendations to address concerns noted by the DFPS investigator. Disciplinary action was taken for two other employees for failure to report the incident and failure to provide adequate supervision. A completion date was given for each action step and documentation was included in the investigative file to indicate that all recommendations were completed.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• For DFPS Case #39908009, DFPS concluded that the four allegations of physical abuse were unconfirmed. According to the UIR completed on the incident, immediate action was taken to ensure the health and safety of the individual involved in the incident. The DFPS investigator recommended that one of the alleged perpetrators be retrained in PMAB techniques. The investigation file included documentation of retraining as recommended. • For DFPS Case #39222987, DFPS confirmed an allegation of physical abuse against one employee and returned an inconclusive finding in regards to a second allegation of physical abuse. There was documentation of immediate protective measures put into place and follow-up disciplinary action was documented in the investigative file. One employee was terminated and the other employee was retrained in PMAB. • In DFPS Case #39634167, the DFPS investigator found the physical abuse allegation inconclusive. After reviewing the completed investigation, the facility requested further review of the case. DFPS again returned an inconclusive finding. The facility overruled the finding and confirmed the allegation based on evidence reviewed. The employee was terminated. No additional recommendations were made. • DFPS Case #39911907 was an allegation of emotional abuse referred back to the facility by DFPS. DFPS did not make any recommendations. The facility investigator recommended that the team meet and discuss the individual's current home placement. Evidence that the team met the day following the incident to discuss placement was included in the investigation documentation. The facility investigation files included documentation of protections put into place and follow-up corrective actions. The facility was in substantial compliance with this item.	
	(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.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team. The team agreed with this facility's self-assessment rating of substantial compliance with this item.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to	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 involved in the incident,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	• Individuals directly involved, • Location of incident, • Date and time of incident, • Cause(s) of incident, and • Outcome of investigation. The facility compiled quarterly trend reports that focused on all allegations of abuse and neglect, other incidents and injuries. Information collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. There continued to be a high number of incidents and injuries at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress. The facility needs to frequently evaluate how data can best be used to evaluate that progress and take action to reduce the number of incidents and injuries. The facility was in substantial compliance with this provision item.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the 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.	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. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 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 and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		completed annually for all employees. Current employees were subject to 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. According to information provided to the monitoring team, for FYI 11, criminal background checks were submitted for 1477 applicants. There were a total of 10 applicants who failed the background check in the hiring process and therefore were not hired. One employee was dismissed due to background check. 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. • All (100%) had a signed acknowledgement on file at the facility. The facility's POI indicated substantial compliance with this D.5. The monitoring team agreed that the facility remained in substantial compliance with this item.	

Recommendations:

1. The facility should assist DFPS in securing evidence and scheduling interviews with witnesses to facilitate expedient investigations (D3b).
2. Investigative activities should commence within 24 hours and activities should be documented (D3e).
3. Investigations should include follow-up recommendations regarding medical care, changes in level of supervision, or behavioral interventions that might prevent similar incidents from occurring in the future (D3e).
4. When there are similar allegations for the same alleged victim or perpetrator, DFPS should document how consideration of those investigations was used in investigations (D3f).
5. DFPS needs to ensure a clear link is provided between evidence reviewed and findings for each case (D3f).
6. The facility incident management coordinator and director should immediately review completed DFPS cases and begin taking action on any recommendations (D3g).
7. Data collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility.

As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to frequently evaluate how data can best be used to evaluate that progress (D4).

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 DADS Draft revised policy on Quality Enhancement, undated o MSSLC facility-specific policy, Quality Assurance, Adm-37, 4/1/11 o Organizational chart, 9/1/11 o MSSLC policy lists, three policy books, July 2011 and August 2011 o List of typical meetings that occurred at MSSLC o MSSLC POI, 9/8/11 o MSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/19/11 o MSSLC DADS regulatory review reports, through 7/21/11 o Training about quality assurance presented to management, 4/11/11 o QA department staff meeting notes, September 2011 (three) o MSSLC Quality Assurance Plan (eight page table/matrix), 8/30/11 o Set of blank tools used by QA department staff (three) o Eight sets of different types of data: • QA department's QA tools • MSSLC Community placements • Off campus outings for individuals • Risk management reports • Summary of departmental and QA department scoring on statewide self-assessment tools • Statewide trend analysis • Statewide data elements table • Statewide FSPI forms o List titled Data pulled from Avatar o Suggestion box submissions and management's responses, 3/9/11 to 8/24/11, 40 pages o DADS MSSLC family satisfaction survey online summary, May 2011-7 respondents, June 2011-2 respondents o Self-advocacy monthly meeting minutes and notes, April 2011 through August 2011 o Executive management meeting agenda and handouts for 9/20/11 meeting o QAQI Council agenda and meeting minutes from 4/11/11 through 9/22/11 (12 meetings) o QAQI Council agenda and handouts for 9/22/11 meeting o PET minutes for all three PET groups, monthly, March 2011 through August 2011 o PET I agenda and handouts for 9/21/11 meeting o Facility-specific policy and attachments for soon-to-be-initiated Performance Improvement Team (PIT), 9/15/11 o Independent Ombudsman's annual report, September 2011

	Interviews and Meetings Held: o Kim Kirgan, Acting Director of Quality Assurance o Charles Bratcher, Director of Quality Services Management o Iva Benson, Interim Facility Director o Etta Jenkins, Settlement Agreement Coordinator o Barbara Shamblin, Bertha Allen, John Parks, Troy Miller, Polly Bumpers, Residential Unit Directors o Terri Moon, Human Rights Officer, and Lynda Mitchell, Assistant Independent Ombudsman o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. Observations Conducted: o QAQI Council meeting, 9/22/11 o PET I meeting, 9/21/11 o Executive management, 9/20/11 o Self-advocacy group, 9/22/11 o Many residences, day program, and vocational program
	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. It was updated on 9/8/11. In addition, during the onsite review, the QA acting director and quality services management division director reviewed the presentation book for this provision and discussed the POI at length with the monitoring team. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the QA staff wrote a sentence or two about what tasks were completed and/or the status of each provision item. An entry was made almost every month. In the POI, similar comments were written for each of the provisions. When the monitoring team conducts its onsite review, the results are 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 POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The QA staff self-rated the facility as being in noncompliance with all five provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI should be written to guide the department in achieving substantial compliance. The action steps for this provision did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). Seven action steps were listed and they all addressed relevant activities, however, the facility will only achieve substantial compliance if a

	set of actions, such as those described in this monitoring report, are set out as action steps. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation, but a timeline that will indicate the stable and regular implementation of each of these actions. The facility will benefit from the eventual development of a self-monitoring tool for this provision of the Settlement Agreement. Perhaps this can occur after the state policy is finalized.
	Summary of Monitor's Assessment: MSSLC made little progress towards achieving substantial compliance with the items of this provision since the last onsite review (at that time the facility was making progress). This was due, in large part, to continuing turnover in the QA director position. Improvement will be necessary in the key areas of this provision: QA policy, QA plan, QA data collection and analysis, QAQI Council and related committees and meetings, and the management of corrective actions. MSSLC was more than ready to have a comprehensive QA program. The program should include, at a minimum, a listing of all data collected at the facility, a QA plan that includes a table/matrix of data that are to be submitted and reviewed by the QA department, the outcome of QA department review of these data, a QA report that includes data submitted to QAQI Council and the other related committees, and a formal corrective action system. Progress was evident in one area: the improvement and expansion of QAQI Council and related committees and meetings. QAQI Council was revamped, more managers and clinicians were included, it met every week, and it was action/outcome oriented. The PET process was expanded to four groups and their agenda, content, and expectations for attendance, participation, and presentation were improved and clarified. Plans for unit-level PITs were laid out, though not yet implemented. QA policy was not yet developed and a QA plan was not fully in place (a table/matrix existed, but it was insufficient as a QA plan). A QA report did not exist. A system of managing corrective actions was not yet in place. All of these components must be in place for the facility to thoroughly review, analyze, and summarize important data. QA staff were competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. QA staff collected a variety of data, and conducted a variety of audits.

#	Provision	Assessment of Status	Compliance
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 made little progress towards achieving substantial compliance with the items of this provision since the last onsite review (at that time the facility was making progress). This was due, in large part, to continuing turnover in the QA director position. At the time of this onsite review, a member of the QA staff was in the role of acting director. This was the third QA director across the last three onsite reviews. Without consistent leadership in QA, the facility will not be able to make progress. To that end, MSSLC was considering reorganization to its quality services management division. <u>Policies and QA Planning</u> This state policy, #003: Quality Enhancement, dated 11/13/09, was being extensively revised. A draft of the new policy was disseminated a few days after the onsite review. Although not finalized, the new policy should provide MSSLC with further direction in its QA activities. There was one facility-specific policy, titled Quality Assurance, Adm-37, dated 4/1/11. It was the same policy that was in place during the previous review. In the previous monitoring report, a number of questions were raised, however, none of them were addressed in a revised facility-specific policy. MSSLC will need to update this policy based upon the new state policy (once it is finalized), comments from the monitoring team in the previous monitoring report (which are not repeated here), and input from MSSLC's own QA department staff. When the new state and facility-specific policies are finalized, training for senior management and department heads should occur. In April 2011, a training session for the facility-specific policy was conducted by the previous QA director. It included a 30 minute presentation and eight-question quiz. This same type of training would be appropriate when the two new policies are finalized. Below are comments from the monitoring team regarding MSSLC's status with some of the important component steps in the development of a QA program. The monitoring team had the opportunity to discuss these at length with the acting QA director, the division director of quality services management, and the interim facility director. Detail is provided here in hopes that it will be helpful to the QA department. 1. Create a listing of all data collected at the facility that includes the following: a. Data collected by each discipline service department; this includes two categories of data: i. Data the discipline service department uses for its own service and operational purposes ii. Data the discipline service department collects as part of its own self-monitoring and which includes these two categories of self-monitoring tools:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Statewide self-monitoring tools • Facility-specific tools created by the facility service department, if any (e.g., PNMP monitoring, AAC device monitoring) b. Data collected by the QA department staff: i. Data they collect themselves ii. Data that are the result of the QA department's interobserver agreement (reliability) assessments of the service department's own self-monitoring c. Data from the areas listed in the Assistant Commissioner's guidelines for QAQI Council, such as Life Safety Code, ICFMR regulatory activities, the FSPI, and any other types of data that DADS central office may determine necessary for submission to state office. Status: MSSLC had not yet begun to assemble this listing. During the week of the onsite review, following discussion with the monitoring team, this was mentioned by QA staff at the QAQI Council meeting. The development of this listing will take a number of months to complete. It is likely that additional items will be added to whatever list is initially developed. Once completed, an annual or semi-annual update will likely be all that will be necessary. MSSLC already collected a lot of data (see below), providing a good starting point for completing this QA task. 2. Determine which of these data are to be submitted to the QA department for tracking and trending (and to be part of the QA plan table/matrix). Status: The QA department had not made any progress on this activity, other than the addition of more items. The table/matrix should indicate all the data that the QA department will track, trend, and comment upon. Further, the table/matrix will become part (the primary part) of the QA plan. Separation of the table/matrix from the overall listing of data (item #1 immediately above) will help the QA department in making this table/matrix and the QA plan functional and relevant. 3. Determine which of these data are to be included in the QA report. Status: A monthly QA report was not being completed. 4. Determine which of these data are to be presented regularly to the QAQI Council. QAQI Council should make this determination with suggestions from the service department heads as well as from the QA director. Status: The QAQI Council and PETs were reviewing some data, discussing those data, and making recommendations (see below), but again, they were doing so without the benefit of a listing of all types of facility data, the QA table/matrix, or any other guidance from the department heads or QA department. The facility planned to initiate five unit PITs to also review data. The PITs would also benefit from being more informed about	

#	Provision	Assessment of Status	Compliance
		the types of data possibly available to them. 5. Create and manage corrective actions based upon the data collected and direction from the QAQI Council. Status: A system of managing corrective actions was not yet in place (see E2 below). QA Department Kim Kirgan was the acting QA director. She also maintained all of her responsibilities as a QA program monitor. The QA department had a different lead person during each of the last three onsite monitoring reviews. As a result, the department never gained much momentum in working towards substantial compliance. To address this, the director of the quality services management division described upcoming restructuring of his department, including the possibility of the quality services management director taking on all QA director responsibilities. This appeared to be a reasonable way to proceed. Facility management will need to ensure, however, that his other duties do not compete with his ability to attend to the many activities required of a well-running QA department. The monitoring team met at length with the acting QA director and quality services management division director during the onsite review. They were both energetic and appeared highly motivated to have a well-running comprehensive QA program. The monitoring team hopes that the discussion was helpful to them as they move forward. Although the QA program had not progressed, every QA staff member was extremely busy and highly engaged in QA activities, including implementing QA's own four or five tools and conducting reliability observations of many of the statewide self-assessment tools. This bodes well for the department as it develops the structure and components required of a QA program. In addition, the department expected to add an additional nurse and, similarly, a QA-related position was recently added to the nursing department, and one was going to be added to the medical department. QA department meetings were initiated in September 2011 and three meetings were held during the weeks in early September 2011 prior to the onsite review. This should continue and should include topics about quality assurance. In other words, the meetings should be used as a staff training-type opportunity so that staff can learn about quality assurance, participate in creating processes for the department and facility, and so forth. One of the topics noted in the minutes from 9/6/11 was that, in the future, statewide scan calls with all QA departments were going to occur and they planned to include the sharing of the way data are presented to QAQI Council at each of the SSLCs.	

#	Provision	Assessment of Status	Compliance
		Statewide scan calls were a good idea and should continue. The Settlement Agreement Coordinator (SAC) also had responsibilities that were quality assurance related. As the QA program develops (i.e., data collection, data analysis, meetings, reorganization), the QA department needs to ensure that the SAC and her activities are appropriately included and involved. <u>Quality Assurance Plan</u> MSSLC did not have an adequate or thorough QA plan in place. The QA plan was the same as during the last onsite review except that additional lines had been added to it. The table/matrix is good to include in the QA plan and can help guide the QA department (and QAQI Council) in understanding what data are being managed by the QA department (some of it collected by QA department staff, some of it submitted by the discipline departments at the facility). Ultimately, the table/matrix should be a component of the QA plan (probably the largest component). Any data/items on the table/matrix should be reviewed, analyzed, perhaps graphed and trended, and commented upon, if necessary, by the QA department. The table/matrix will also likely include more detail about how each of these types of data will be obtained (e.g., by whom, how often, what tool, sample size). MSSLC's table/matrix indicated more than one measurement, sampling, and/or responsible person for some of the items. This was good to see and was appropriate to include. The current MSSLC table/matrix, however, combined what should be two separate activities: the listing of all data collected at the facility, and a designation of what should go to the QA department for tracking and trending. The latter is what should be on the table/matrix. The former should be a separate, ever evolving document. The monitoring team and the QA acting director and quality services management director discussed this at length during the onsite review. The new state policy should provide guidance to the facility regarding the content of a QA plan. A QA plan will be a description of the overall QA program at the facility. Therefore, it should include a narrative in addition to the table/matrix. The QA plan narrative should describe all of the activities conducted by the QA department. <u>QA Activities and Indicators</u> The activities of the QA staff were primarily: • Completion of their three (or so) data collection tools • Completion of statewide self-monitoring tools for the purpose of interobserver agreement with discipline department	

#	Provision	Assessment of Status	Compliance
		• Participation on various committees and attendance at various meetings • Responding to ICFMR regulatory actions MSSLC was not without sets of data. These were submitted to the monitoring team in various formats, such as raw data, tables, graphs, and/or completed tools. As a result, it was difficult, if not impossible, for the monitoring team to understand much of these data and how they fit into the facility's QA program. Moreover, MSSLC did not engage in any analysis of these data (except for the state-required trend analysis). MSSLC will need to assess all of these currently collected data sets and determine how (or whether) to include them in an organized QA program. Some of these data will end up on the list of data collected at the facility, but not submitted to and reviewed by the QA department. Other data sets will be submitted to and reviewed by QA, QAQI Council, and MSSLC's PETS and PITs. These data sets are listed below, in hopes that this is helpful to the facility. • QA department's QA tools • MSSLC Community placements • Off campus outings for individuals • Risk management reports • Summary of departmental and QA department scoring on statewide self-assessment tools • Statewide trend analysis • Statewide data elements table • Statewide FSPI forms • Data that can be pulled from Avatar • Suggestion box submissions and management's responses • DADS MSSLC online family satisfaction survey online • Self-advocacy monthly meeting minutes and notes Below are comments on some of these data sets: • Data from one of the QA department's three QA tools was summarized in line graph by topic and by unit. Graphic summaries were great to see. It was not clear, however, if the data were reviewed and/or used by anyone at the facility. Also, whenever there was a month with no data, the graph presented this as a zero. This distorted the visual presentation of the graph and should be fixed. • Data for community outings was presented as a percentage. The graphs, however, did not indicate if that meant percentage of individuals who went on outings that month or if it was some other percentage. The sample recording log indicated the number of individuals who went on an outing. Thus, it was possible that the data represent the total number of outings that occurred, not the total number of individuals who went on an outing.	

#	Provision	Assessment of Status	Compliance
		• Data from the online family survey was not reviewed or used by the facility. • Every suggestion box items was taken seriously and a response was made. Data should be summarized, too. In addition, as noted in previous monitoring reports: (a) satisfaction measures should also target others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth, and (b) home meetings (called peer councils) should be incorporated into the data regarding individual satisfaction, along with self-advocacy group information, and any other methods the facility develops to assess individual's satisfaction.	
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 had made progress in one aspect of this provision item: development of the QAQI Council, PET groups, and planning for PITs. Overall, to meet the requirements of this provision item, MSSLC needs to (a) analyze data regularly, and (b) act upon the findings of the analysis. <u>QA Data Management and Analysis</u> As the facility moves forward, it will be important for the QA director to review all data that are managed by the QA department (i.e., all of the data on the table/matrix). These data will need to be summarized and trended, such as on a graph. The graphic presentations should show data across a long period of time. The amount of time will have to be determined by the QA director, perhaps in collaboration with the department or discipline lead. For most types of data, a single data point on the graph will represent the data for a month, two-month period, or quarter. The graph line should run for no less than a year. Not all of these graphs need to be created by the QA department. It is possible for the facility to set an expectation for the service departments to submit their data and their graphic summaries each month. This will have to be determined at the facility level. Many, if not all, of these graphic presentations should/can appear in the QA report and be presented to QAQI Council. Regarding the statewide trend analysis: for the past few years, every SSLC created an almost identical monthly report on four sets of data: restraint usage, abuse and neglect allegations, injuries, and unusual incidents. These are important topics and the report typical provided a lot of valuable information. Each facility now had data for three or so years. The document, however, was cumbersome and lengthy. The QA director will need to take the most important parts of this trend analysis document and incorporate them into the facility's QA program (e.g., table/grid, QA report, report to QAQI Council).	Noncompliance

#	Provision	Assessment of Status	Compliance
		Other comments regarding the status of MSSLC's data analysis and management are presented in E1 above, under the subsection QA Activities and Indicators. QA Report MSSLC did not have a QA report. To clarify and perhaps reiterate: the list of data collected at the facility, the QA plan, the QA department's analysis and trending of data in the QA plan, the QA report, QAQI Council agenda and reviews, PETs, PITs, and CAPs should all line up with each other. QA-Related Meetings The interim facility director reorganized the QAQI Council meeting, reformatted the PET meetings, and began plans for unit level PIT meetings. Overall, more management and clinical staff were included in these QA-related activities. Many of these managers and clinicians reported to the monitoring team that they were very pleased to be involved. As these groups become larger and more inclusive (a good thing), the facility director will need to ensure that the groups can be effective, given their size. • QAQI Council: The QAQI Council met regularly since the last onsite review. The interim facility director, upon her appointment in September 2011, held these meetings each week. Moreover, many more managers and clinicians attended and participated. The format and agenda of the meetings were also updated. The current agendas contained new business, old business, regulatory topics, and policy/procedure status. This appeared to be an efficient way to manage this meeting. The facility director, as reflected in her leadership during the meetings and in the agenda and minutes, regularly and continually referred to topics by their corresponding Settlement Agreement provision letters. This kept all participants focused upon the Settlement Agreement highlighting how it directly related to the topic at hand. The meeting observed by the monitoring team was attended by about 40 people. • Performance Evaluation Teams: PETs were also reformatted since the appointment of the interim facility director. The Settlement Agreement provisions were now split across four (rather than three) PETs and each meeting was now led by the interim facility director, rather than the SAC. Attendance at these meetings was expanded in a manner similar to the QAQI Council described above. The agenda and expectations for participation, presentation, and data submission were still be clarified and developed (e.g., a nine-question format for each division head to use when presenting his or her department's status on Settlement Agreement provisions), but represented a more focused and out-come oriented approach. When data (graphed) were presented, there was more active participation by attendees (e.g., delinquent documentation graphs presented by the URCs).	

#	Provision	Assessment of Status	Compliance
		• Performance Improvement Teams: A policy and procedure was developed the week before the onsite review by the interim facility director. Implementation had not yet occurred. The plan, however, was for each unit to have a monthly meeting, led by the unit director, during which data from the residential and clinical discipline departments were to be reviewed. It is likely that the meeting agendas and format will be modified as implementation occurs, however, the PIT appeared to be a good addition to the set of QA-related meetings that were occurring at MSSLC. Corrective Actions Corrective actions were not yet being addressed in any organized manner and as required by provision items E2-E5. The monitoring team has a number of considerations for the facility as it moves forward with meeting the requirements provision items E2-E5. These considerations were in the previous monitoring report and are repeated here for the convenience of the QA department. These could be included in MSSLC's facility-specific policies regarding QA and the QAQI Council and the related PET and PIT meetings. • 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). • 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 specialized team to address the action and report back to the group. • 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.	

#	Provision	Assessment of Status	Compliance
E3	Disseminate corrective action plans to all entities responsible for their implementation.	MSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	MSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	MSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

Recommendations:

1. Implement new state policy (E1).

2. Revise facility policy Adm-37 to be in line with new state policy (see comments in E1) (E1).

3. Provide training to management and clinical staff (and perhaps PET and PITs) on QA and on the new state and facility policies (E1).

4. Implement the five component steps numbered and described in E1
    - Create a listing of all data collected at the facility.
    - Determine which of these data are to be submitted to the QA department for tracking, trending, and inclusion in the QA plan table/matrix
    - Determine which of these data are to be included in the QA report.
    - Determine which of these data are to be presented regularly to the QAQI Council, the PETs, and/or the PITs.
        - QAQI Council should make this determination with suggestions from the department heads as well as from the QA director.
    - Create and manage corrective actions based upon the data, and direction from QAQI Council (E2-E5).

5. Add trainings/topics about quality assurance to the QA department's meeting agendas (E1).

6. Include the SAC in QA activities as they relate to the Settlement Agreement (E1).

7. Develop the QA plan and the table/matrix of data (E1).

8. Create a QA report; summarize and present data in an understandable manner (E2).

9. Include range of satisfaction measures in the QA program (e.g., individuals, staff, families, and related community businesses) (E1, E2).

10. Implement and manage corrective actions as per items E2-E5 (E2-E5).

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:** Documents Reviewed: o Documents for the following individuals:

Individual	PSP	PSPAs	PFA	Assess-ments	Risk Rating Form	Specific Program Objectives	PBSP
#244	2/9/11			Y		Y	
#592	7/25/11	Y	Y	Y	Y	Y	Y
#570	3/4/11		Y				
#42	2/16/11		Y				
#521	4/20/11						
#359	5/4/11	Y		Y	Y		
#227	4/18/11						
#39	7/26/11	Y	Y	Y	Y	Y	Y
#331	3/29/11	Y			Y		Y
#242	7/5/11						
#108	7/7/11		Y	Y	Y		
#115	7/27/11		Y	Y	Y		
#284	7/26/11	Y	Y	Y		Y	with SPCI
#126	2/9/11	Y					with SPCI
#483	2/17/11	Y					with SPCI
#588	2/17/11				Y		Y
#319	3/28/11						
#376	7/13/11						
#6	3/31/11						
#422	5/19/11						
#264	5/24/11						
#461	7/6/11						

- o A sample of monthly reviews for:
  - Individual #39, and Individual #115
- o A sample of 25 QMRP Monthly Review Monitoring Tools
- o Completed Section F Audit Tool for
  - Individual #43, Individual #570, Individual #51, Individual #591, Individual #177, Individual #244, Individual #391, Individual #216, and Individual #438.

	o Training transcripts for 24 employees o MSSLC Plan of Improvement o MSSLC Section F Presentation Book o Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o Supporting Visions Training Curriculum <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Charlotte Kimmel, PhD, Director of Psychology o Valerie McGuire, QDDP Director o Terri Moon, Human Rights Officer o Charles Bratcher, Quality Services Director o Justin Vest, Risk Officer o Pat Samuels, Incident Management Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Daily Incident Management Review Team Meeting 9/19/11 o Longhorn Daily Unit Meeting 9/21/11 o Restraint Reduction Committee Meeting 9/22/11 o Human Rights Committee Meeting 9/20/11 o Risk discussion meeting for Individual #524 o PSPA meeting for Individual #37 o Quarterly PSP meeting for Individual #128 o Annual PSP meetings for Individual #360 and Individual #123
	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. It was updated on 9/8/11. During the onsite review, the QDDP director reviewed the presentation book for this provision. The facility reported that it was focusing on problems noted in Section F, but acknowledged that many of these efforts were in the beginning stages. Most of the items required by this provision were not yet fully implemented. The QDDP director was focusing her efforts on evaluating each QDDP's facilitation skills and PSP development skills, and providing mentoring and feedback where needed. According to the POI, the facility's self-rating was, in part, determined through monitoring of the PSP and PSP process using audit tools developed by the State Office. The facility began auditing PSP development in May 2011. The POI did include results of that self-assessment process. The POI did not indicate how the findings from any activities of self-assessment were used to determine the

	self-rating of each provision item. Compliance percentages were given, but compliance ratings for each section were not necessarily based on the percentage in compliance. For example, the facility found a 95% compliance rating for F2f, but the POI indicated that the facility was not in substantial compliance with this item. The facility assigned a noncompliance rating to all provisions in Section F. The monitoring team agreed with this assessment The POI indicated that actions had been taken to address compliance with Section F in the past six months: • A shared folder was created for disciplines to place copies of assessments for review by all team members prior to PST meetings. • A QDDP Educator was hired by the facility. • All QDDPs had attended Facilitation Skills training. • The QDDP Construction Facilitating for Success Performance Tool was implemented. • Audits were completed for eight individuals on the Settlement Agreement Cross Referenced with ICF/MR Standards Section F: Integrated Protections, Services, Treatments, and Support review tool, various dates in May, June, July, and August 2011 • The QDDP director had observed PSP meetings and provided immediate feedback to QDDPs leading the meetings. • QDDPs began using an attendance tracking database to track attendance at annual PSP meetings. As noted throughout section F, while the monitoring team did see continued progress in this area with the new style PSPs, assessments were still not completed or updated as needed, plans still did not integrate all services and supports, and plans were not consistently implemented and revised when needed.
	Summary of Monitor's Assessment: The facility was not yet in substantial compliance with requirements of this provision. It was evident from conversations with the monitoring team that the facility was still considering how to best implement the person centered planning process and ensure consistent implementation and monitoring of services. All staff had also been trained on the new risk identification process and the process had just been implemented for some individuals at the facility. Moreover, DADS had recently initiated a thorough review of the PSP process and hired a set of consultants to help the SSLCs move forward in PSP development and the meeting of this provision's requirements. The consultant's work had not yet begun at MSSLC. In light of the many changes occurring with the risk identification process and PSP development and implementation, the monitoring team did not expect to find substantial compliance with the provisions in Section F. A number of PSP meetings were observed by the monitoring team. In meetings observed, the QDDPs were attempting to encourage team participation and ensuring that all necessary information was covered

	during the PST meeting. Most of the information regarding assessments and supports was presented by individual team members and very little discussion took place among team members to integrate information shared. Information regarding supports that individuals need throughout the day was still not clearly stated in the newer PSPs. There was not much progress being made on developing plans that would lead to a more meaning full day for individuals. Plans were not written that would guide support staff in providing consistent supports to ensure risk was minimized for individuals. Quality assurance activities with regards to PSPs were in the initial stages of development. Audit tools had been developed to review both meeting facilitation and the PSP development process. The facility had been using the state developed audit tools since May 2011. The facility used data gathered through this process to determine compliance with each provision. Compliance with section F 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 PSPs that were reviewed were chosen from among the list of individuals for whom the new format/process for PSPs had been used. The monitoring team reviewed a sample of 22 of the new plans. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and PSTs had been responsible for the development of the plans reviewed.

#	Provision	Assessment of Status	Compliance
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:		

#	Provision	Assessment of Status	Compliance
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 at the facility. The QDDPs were responsible for ensuring that team members were developing, monitoring, and revising treatments, services, and supports. While onsite, the monitoring team observed a number of PST meetings, including annual and quarterly meetings, PSPA meetings, and also met with a PST to discuss the at-risk screening process. All PST meetings observed during the monitoring visit confirmed that PSP Coordinators were facilitating PST meetings. A sample of 10 PST attendance sheets was reviewed for presence of the PSP Coordinator and QDDP at the annual PST meeting. • This sample included PSP signature sheets for Individual #592, Individual #422, Individual #376, Individual #319, Individual #242, Individual #331, Individual #521, Individual #6, Individual #461, and Individual #284. • At all annual meetings, both the PSP Coordinator and the QDDP were present. Some progress had been made with regard to tracking attendance at PSP meetings. Specifically, a database had been set up, and in May 2011, the facility began tracking attendance of key team members at annual PST meetings. Data collected in May 2011 indicated that the facility was at 100% compliance with QDDPs attending annual meetings. All QDDPs and PSP Coordinators had attended facilitation skills training on 4/29/11. While it was too soon to fully evaluate the effectiveness of this training, the QDDP director was attending annual PST meetings and continuing to mentor PSP Coordinators and QDDPs with regards to meeting facilitation. The QDDP director reported that QDDPs were at varying stages in learning to competently facilitate meetings and ensure adequate team participation. Although the monitoring team observed more integrated discussion at PST meetings, PSP Coordinators were still struggling with trying to ensure all necessary topics were covered at meetings while encouraging open discussion among team members. For this provision to be in compliance, not only does the PSP process need to be facilitated by one person, but also team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year. This will be a key component to achieve compliance with a number of sections of the Settlement Agreement. As noted throughout this report, this did not always occur. The facility was had begun auditing records for compliance with provisions in section F. Eight record reviews were completed between May 2011 and August 2011. The facility	Noncompliance

#	Provision	Assessment of Status	Compliance
		POI indicated a 75% compliance rate with F1a. The POI did not indicate what criterion was used to determine this compliance percentage. At the June 2011 Monitors' meeting with DADS and DOJ, there was discussion regarding determining the definition and criteria for facilitation, that is, what does it mean for the QDDP to facilitate the PST in a way that meets this provision item. The facility's POI indicated noncompliance with this requirement. The monitoring team agrees with that assessment.	
F1b	Consist of the individual, the LAR, 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.	A sample of attendance sheets was reviewed with the following results in terms of appropriate team representation at annual PST meetings. The sample included PSPs for the 10 individuals listed in section F1a. • 9 (90%) of 10 indicated that the individual attended the meeting. The exception was Individual #588. His LAR requested that he not attend. • 6 (60%) of 10 individuals had an LAR; 2 (33%) participated at the annual PST. o Exceptions were the LARs for Individual #6, Individual #331, Individual #319, and Individual #422. This finding was similar to the facility's self assessment for meeting attendance. According to a compliance summary from May 2011, the facility also found individual attendance to be at 100% compliance and LAR attendance to be at 38% compliance. The monitoring team does not expect that all LARs will want to attend PST meetings. When individuals are not present for meetings, the QDDP should document attempts made to include the LAR and how input was gathered to contribute to planning if the LAR did not attend the meeting. If LARs are consistently not contributing to planning and decision making for individuals, the team should discuss the need for an advocate for the individual. A review of 10 signature sheets for participation of relevant team members at the annual PST meeting indicated that 10% of the meetings were held with <u>all</u> relevant staff in attendance. The PSP that indicated all relevant staff were in attendance was for Individual #242. There was no documentation included in any of the PSTs that would indicate input was given prior to the meeting by staff that were unable to attend the meeting. Psychiatric staff were not in attendance at any of the meetings (0%) in the sample. Psychiatric services were an integral support for six of the individuals in the sample. Input from the psychiatrist would have been valuable in the team's discussion of supports and services. The absence of key team members at annual meetings was a significant barrier to	Noncompliance

#	Provision	Assessment of Status	Compliance
		integration in the development of PSPs. As a result, the PSPs continued to be discipline-specific with excessive reliance on the written assessment. It would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective support plans to address these issues in the absence of key support staff without comprehensive and timely assessment information. The following are comments regarding participation in PST meetings for this sample. • The signature sheet for the annual PST meeting for Individual #422 indicated that all relevant team members were not in attendance at the annual PST meeting. Her LAR did not attend the meeting and the psychiatrist was not in attendance. According to her PSP, she needed psychiatric support services. She was at risk for polypharmacy because she was taking three psychotropic medications. • For Individual #331, the psychiatrist and SLP did not attend his meeting. He had needed supports in both of those areas. • For Individual #521, her OT and PT did not attend the meeting. There were many changes made in her PNMP and PNM supports were needed throughout her day. Work was listed as a priority preference. Vocational staff did not attend her PST. • The dietitian and psychiatrist did not attend the annual PST meeting for Individual #461. His PSP indicated that he had diabetes and was at high risk due to the severity of his diabetes and his refusal to comply with treatment of his diabetes. His PSP also indicated that he had frequently refused to take his psychotropic medication. Participation by both of these team members in discussion regarding supports would have been beneficial. • For Individual #284, the attendance sheet did not indicate participation by the psychiatrist. His PST noted that he takes multiple psychiatric medications and was at high risk for polypharmacy. Vocational staff did not attend the meeting, although, work was listed as a priority preference. Communication supports were needed throughout his day according to his communication assessment. His SLP did not attend his meeting. The facility completed a self-assessment of attendance at team meetings by completing six record reviews from May 2011 through July 2011. Data indicated a compliance rate of 90%. The monitoring team found a 10% compliance rate with this provision.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient	The facility had begun to use a database to determine if assessments were being completed and shared with the PST at least 10 days prior to the annual PST date. According to the POI, the facility had assigned a 45% compliance rate to this provision based on data gathered May 2011 through July 2011.	Noncompliance

#	Provision	Assessment of Status	Compliance
	quality to reliably identify the individual's strengths, preferences and needs.	As noted in F1b, some PST members were not routinely attending annual PST meetings and without assessments to review, team members did not have the information needed to develop appropriate supports. The monitoring team found the quality of some assessments continued to be an area of needed improvement. In order for adequate protections, supports, and services to be included in an individual's PSP, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed (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 facility used the Personal Focus Assessment (PFA) to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. The PFA process also identified other assessments to be completed prior to the annual PST meeting. In the PSPs reviewed, the PFA was used to develop a list of priorities and preferences for inclusion in the annual PSP. This list was individualized in the PSPs in the sample and offered a good starting point for plan development. Seven of the PSPs developed in July 2011 were reviewed to determine if the list of preferences was adequate for planning. The following are comments regarding those PSPs. • All (100%) were individualized and based on current assessments. • None (0%) included enough information to guide staff in providing supports based on individual preferences. • None (0%) described preferences for daily schedules. Given the high number of refusals noted, this type of information would be critical for support staff to know. Structuring an individual's day to encourage participation often relies on knowing information such as: o Does the individual like to wake up early or sleep in? o Does he/she like quiet time in the morning? Or need some quiet time after work to wind down? o Does he/she need coffee in the morning before getting dressed? o Does the individual prefer to shower/bathe in the morning or evening? o Is he/she more productive at work in the morning or afternoon? o Does the individual enjoy watching movies in the evening or playing sports?	

#	Provision	Assessment of Status	Compliance
		○ Does the individual like to engage in time alone on the weekends? Or spend time with friends and family? • Outside of general comments regarding family or staff, relationships were not addressed in preferences. There needs to be a stronger focus on supporting individuals to develop and maintain relationships with people that are not paid to spend time with them. If an individual does not have important relationships listed in preferences, then supports should be in place to provide opportunities for the individual to develop relationships. • None (0%) of the list included dislikes or things that the individual does not tolerate well. Along with likes, this information should be shared with support staff so those situations can be avoided or appropriate supports can be in place (e.g., fear of dogs, loud noises, crowded rooms, cold weather) The Positive Assessment of Living Skills (PALS) was used by the facility to assess adaptive living skills. PALS assessments were provided to the monitoring team for four individuals in the sample. Completed PALS were reviewed for Individual #284, Individual #115, Individual #39, and Individual #108. • The checklist portion of the assessment was completed. None of the assessments described specific supports needed by the individual. • Section III of the PALS was a summary section that should have been used to develop a list of recommendations and priorities for training objectives. The summary section was not completed for any of the assessments in the sample. Section F audits completed by the facility indicated that three out of eight (38%) individuals had PALS assessments updated prior to the annual PST meeting. The monitoring team's understanding is that the PALS was being revised by DADS and would either be updated or replaced with a more useful tool. An assessment geared towards identifying activities not typically offered at the facility would broaden the spectrum of preferred activities that individuals may want to be involved in during his or her day. Consideration should be given to capturing and sharing information regarding possible areas of interests while individuals are in the community. The Vocational Director reported that attempts were being made to gather this information, but no formal process was in place to share the information gathered during team meetings. This information should be discussed at the PST meeting and the team should plan for opportunities that might lead to discovering new activities that the individual might enjoy for recreation, leisure, and work. Some examples where adequate assessments were not completed for the individual prior	

#	Provision	Assessment of Status	Compliance
		to the annual PST meeting, or updated in response to significant changes included: • Individual #592 and Individual #284 did not have guardians. There was no indication that either had a recent psychological or psychiatric assessment. Assessments provided to the monitoring team did not adequately address cognitive functioning or ability to provide informed consent. • Individual #284 stated that work was a priority and working in the community one day was his dream. An adequate vocational assessment had not been completed prior to his PST meeting. His vocational assessment did not assess areas of work interest outside of his present job or describe supports that he needed to complete his job at the sheltered workshop. It did not appear that the team had an updated psychiatric assessment or recommendations to consider when developing supports at his annual PST meeting. • Individual #39 did not have a vocational, psychiatric, or cognitive assessment submitted to his team for review prior to his annual PST meeting. • Individual #570 did not have a PALS or other functional assessment completed prior to his annual PST meeting. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the PST meeting to facilitate adequate planning.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As noted in F1c, it was not evident that assessments were being completed and shared with the PST at least 10 days prior to the annual PST date or that assessments were always adequate to address needs and were revised as individual's needs changed. These requirements will be a prerequisite to developing adequate plans that outline the protections, services and supports to be provided to each individual. Although there was a noticeable improvement in plans developed over the two months prior to the monitoring visit, a sample of the newer style PSPs indicated QDDPs were still not integrating information into a more meaningful plan that identified all needed supports in relation to the individual's preferences and needs. PSPs should be a guide to providing supports that all staff can understand and follow. The facility's self audit indicated a 45% compliance rate with this provision. It was not clear, however, how the facility arrived at this determination. The facility was using the Personal Focus Assessment to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. In the PSPs reviewed, the PFA was used to develop a list of priorities and preferences for inclusion in the annual PSP. As noted below, not all preferences identified were included in the PSP, or if included, necessary supports were not	Noncompliance

#	Provision	Assessment of Status	Compliance
		developed to ensure the preference was a part of the individual's day. Comments regarding the integration of assessment results into PSPs: • Each PSP in the sample included a list of preferences followed by the statement: "The preferences that are listed above are important, but they are not things that he/she needs daily or they are things that he/she already gets daily and does not need added supports to get them." In most cases, individuals would need added supports to ensure preferences listed were a part of their day. For example, Individual #39 stated that he wanted to work at Pizza Hut. His desire to work at Pizza Hut was restated in his PSP, but the PSP did not discuss supports that he would need to obtain a job in the community. • Some information in the PFA that should have been used to develop supports was not carried over into the PSP. For example, the PSP for Individual #592 included a list of preferred activities developed from information gathered in the PFA process. It was also noted in his PFA that quiet space was important to him; he liked having a consistent schedule; and time to be alone. This information was not included in his preferences or used for planning. Similarly, Individual #284's PFA included the following preferences that were not included in his PSP: go to college, work in the community, warm weather activities, and loud environments. • At the PST meetings observed, each PSP Coordinator reviewed the individual's list of preferences, and then a representative from each discipline reported assessment findings for their specific area. Rather than developing outcomes at this point in the PSP process based on information shared, staff from the education and training department then presented a list of outcomes prepared prior to the meeting. Outcomes should be developed following team discussion regarding preferences and needed supports. • Plans offered little indication of how each individual spent a majority of the day. A description of each individual's day along with needed supports identified by assessment should be included in PSPs. • Recommendations included in assessments were not always considered in the development of teaching strategies for outcomes. Examples, where assessments included important information that should have been used to develop and implement protections, services, and supports for the individual: o The communication assessment for Individual #108 included specific recommendations for training methods. These recommendations were not included in the teaching methodology for her SPOs. o Communication outcomes were not included in the PSP for Individual #359 though his assessment recommended the use of a communication wallet and speech therapy services.	

#	Provision	Assessment of Status	Compliance
		The facility was in the beginning stage of ensuring assessment information was used to develop plans that outlined all supports and services. The QDDP director recognized the challenges in achieving compliance with this provision and was working with QDDPs to ensure progress in this area.	
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).	Observation throughout the facility's day and residential programs revealed that individuals were involved in minimal programming that would provide meaningful learning opportunities to develop new skills and increase opportunities for community integration. A sample of 10 PSPs was reviewed for indication that individuals and/or their LARs were offered information regarding community placement as required. All 12 (100%) indicated that this discussion took place at the annual PST meeting. In eight of 10 (80%) instances, the team concluded that the individual should continue to reside at MSSLC. Two individuals (Individual #521 and Individual #461) were referred for community placement. As evidenced by the summary below, this discussion, however, was not always adequate (also see section T of this report). • Individual #461 indicated that he wanted community placement. His advocate agreed that community placement would be the optimal placement. The team planned to reconvene in two weeks with the appropriate MRA to make a referral for community placement. • Individual #284 and his father (advocate) stated that optimal placement would be in the community. The PSP noted that behavioral issues and possible unresolved court issues prevented the team from recommending community placement. The PSP did not indicate what would have to occur for the team to consider a referral for community placement or when the team would consider the individual's request again. There was no discussion regarding his ability to make decisions regarding placement or the need for a guardian. • The PSP for Individual #595 indicated that he would like to move to a group home in the community. Physical aggression towards others was determined to be an obstacle to placement in the community by the team. The team concluded that "until his behaviors improve and aggression is virtually non-existent," he would not be considered for community placement. His advocate requested that a minority view point be filed because the PST did not reach a consensus on community placement. It further noted that the individual was the only team member in favor of community placement. The team did not discuss his ability to give informed consent and a referral for guardianship was not recommended. • Individual #108's guardian wanted her to remain at MSSLC. The CLOIP MRA did not attend the meeting and outcomes were not developed to educate the	Noncompliance

#	Provision	Assessment of Status	Compliance
		individual or her guardian on other living options. The team concluded that MSSLC was optimal placement due to the guardian's opinion. There was no discussion regarding whether her support needs could be met adequately in the community. • Individual #376's PST determined that MSSLC was the optimal living placement for her. It was noted that she had limited exposure to the community. Outcomes were included in her PSP for education regarding living options and exposure to the community. • The PSP for Individual #6 indicated that his guardian was opposed to community placement due to unsuccessful group home placements in the past. The PSP noted that behaviors that had contributed to those unsuccessful placements had improved in the past year. The team determined that he should remain at MSSLC and "continue to make behavioral improvements." There was no indication what "behavioral improvements" would be needed before the team would consider community placement or why his behaviors could not be supported in the community. • The optimistic living vision for Individual #249 was a home in the community. The team determined that he could be successful in the community, but he did not have citizenship, so funding was not available for community placement. The team did not develop outcomes to ensure community participation or greater exposure to community living options. • Individual #422's PSP indicated that living options had been discussed with her guardian. Her guardian stated that she would leave the decision up to her team to determine optimal placement since they knew her best. The team determined that her behavior was an obstacle to community placement. The PSP noted that the MRA had not provided information to the individual regarding living options because she would not understand the information. The team determined that she should continue to live at MSSLC. There were some common themes among the discussion and determination of optimal living placement in the PSPs reviewed: • Behavior was considered the obstacle for community placement in all eight instances where optimal placement was determined to be MSSLC. • Criterion for determining when behavior would no longer be considered an obstacle was not discussed by any of the PSTs. • How appropriate behavior supports could be provided in the community was not discussed by any of the PSTs. PSTs need to give consideration to the following: • The primary focus of all PSTs should be to provide training and supports that	

#	Provision	Assessment of Status	Compliance
		would allow each individual to live in the most integrated setting possible. • Communication skills, decision-making skills, and increased exposure to life outside of the facility should not be considered barriers to living in a less restrictive setting. When identified as a priority need by the PST, these skills, however, are likely to support greater success and independence in less restrictive settings. • Team members need to be provided with updated training on services and supports that are now available in the community. • As evidenced throughout this report by the number of confirmed abuse and neglect allegations, injuries, incidents of substandard or compromised care, and lack of appropriate services available, MSSLC may not be the safest or optimal living environment for all individuals. The team needs to review each individual's history of incidents and injuries, any decline in health status, or regression in skills and hold an integrated discussion regarding whether or not the facility is able to provide the best care possible for each individual. Plans still included limited opportunities for community based training. Opportunities to develop relationships and gain membership in the community were not addressed in any of the plans in the sample. Although the facility reported that some training was occurring in the community, it was not evident in PSP outcome documentation. Plans will need to include community based teaching strategies to ensure that training is consistent and measurable. 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. This provision is discussed in detail later in this report with respect to the facility's progress in addressing section T.	
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:		

#	Provision	Assessment of Status	Compliance
	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;	As noted in F1c, PSTs were not adequately identifying individual's preferences and support needs. In order to gain compliance with this provision, the facility will first have to identify preferences, strengths, and needs through the assessment process. PSPs reviewed were reflective of the lack of options and programming available at MSSLC. A number of BSPs in the sample addressed refusals to attend work or programming with reward systems for attendance. Teams should consider revising programming to include activities related to the individual's preferences when the individual refuses to participate in programming. For example, at the annual PSP meeting for Individual #123, the team discussed a recent increase in aggressive behavior. He was refusing to go to work more often and choosing to sit outside on the bench. He became upset when asked to return to work. The team agreed that his BSP needed to be revised to address this behavior. There was no discussion regarding what he would prefer to be doing during the day. The team should have talked about programming options to allow him to choose between jobs or have additional leisure time, possibly engaged in new activities appropriate for his age and stage in life. An example of where a PSP did appropriately address refusals to attend programming by looking at preferences was for Individual #592. The team met to discuss his refusal to attend Life Skills training. He informed the team that he did not like his Life Skills instructor. The team requested that he be transferred to another instructor. Once the transfer occurred, he began attending training again. The seven PSPs in the sample developed after 7/1/11 were reviewed to determine if preferences and priority needs that had been identified by the team were addressed in the PSP. None (0%) of the plans reviewed adequately addressed individual's preferences and support needs. • The PSP for Individual #108 did not include any objectives based on her list of preferences. Staff commented in her PALS assessment that she "comes to work, locates her work station, starts working without being told to do so, and remains seated without interfering with others." Her PSP included a priority objective in the area of workplace behavior to remain on task for 30 seconds. It was not clear how this related her assessed needs or preferences. • For Individual #242, the three preferences that were identified that he needs the most supports with were time to cool off, computers, and cooking. Supports needed were not identified in the PSP. His behavior was listed as an obstacle to community placement. The PSP did not identify what changes would have to occur in his behavior for the team to consider community placement. • The PSP for Individual #376 did not describe what supports were needed throughout her day. She had numerous support needs referenced in her OT and	Noncompliance

#	Provision	Assessment of Status	Compliance
		PT assessments. Her PNMP was written as a stand alone document and support needs were not integrated into her PSP. Medical assessment information was copied into her PSP, but there was no discussion of how support staff should monitor her multiple health care risks or what healthcare supports were needed throughout her day. • Individual #284's PSP included a list of preferences developed from his PFA. Outcomes developed by the team did not address his preferences. • Individual #115's list of preferences included shopping and going out to eat. His PSP did not include any training in the community or ensure that he would have opportunities to participate in community outings. Communication strategies were not included in teaching strategies for any of his SPOs. • Individual #39's long range vision included living and working in the community. He had no outcomes related to community exposure. His dental assessment indicated that he had poor oral hygiene and periodontal disease. The dentist attributed his periodontal disease to poor care at home. His plan did not address dental hygiene supports needed at home. As noted in F1e, outcomes were not functionally implemented in the community. There was no focus on priority skills, such as communication, socialization, and community integration. The PSTs should have developed action steps that would facilitate community participation while providing learning opportunities for skills that could be utilized for positive community integration. The PSTs should have developed action steps that would facilitate community participation while learning valuable skills needed in the community for most individuals in the sample. Although, the facility had a "community based" program, PSPs in the sample reviewed did not include outcomes for participation in the program. There was no evidence that structured training was occurring in the community. Individuals at the workshop should have been learning work skills that would transfer into employment skills for the community with the opportunity to make real wages in an integrated setting. Progress made on each vocational outcome should move the individual closer to community employment. Work outcomes tended to be just a continuation to work in the same job without any measurable outcomes to learn new work skills. DADS had recently contracted with a set of consultants to help bring about change in the overall PSP process, including development and implementation. It is expected that there will be a focus on helping teams develop plans to address preferences and needed supports.	

#	Provision	Assessment of Status	Compliance
		The facility's POI indicated noncompliance with this requirement. The monitoring team agrees with that assessment.	
	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;	Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. For example, rarely was the focus of the PNMP identified as a measurable outcome in the PSP actions. PSPs in the sample reviewed did not consistently specify individualized, observable, and/or measurable goals and objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet identified needs. Outcomes were not written to address all preferences and were not written in a way that progress or lack of progress could be consistently measured. Outcomes regarding medical, therapy, and behavioral needs were broadly stated and did not specify how data would be collected or progress measured. For example, in the PSP for Individual #592, one of the measurable steps that would be taken to reach his outcome to maintain health stated, "will maintain his good health status by going to all medical appointments, including dental, vision, and psych clinic, taking medications ordered for his acne, chronic constipation, and his multivitamin; and by the psychiatrist for any psychiatric symptoms." MSSLC submitted 22 PSPs and associated documents for review by the monitoring team. None of the PSPs in this sample included a PNMP, health care plan, or risk action plan. This was indicative of the overall view at the facility that these plans were not an integral part of the PSP. None of the 22 plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. The health services portion of the plan, similar to the PBSP and PNMP, frequently still were separate plans that were not integrated in any measurable way into the PSP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. Examples of issues related to the lack of integration were found between nursing and physical and nutritional supports to incorporate PNMPs with medication administration, and dental and psychology to develop and implement desensitization plans. There was little evidence that PBSPs were integrated with other supports, such as communication supports, or health related supports (e.g., weight reduction, medication administration, etc.). All of these are examples of coordination and integration that should be occurring as part of the individual planning process. Teams were not consistently identifying measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. See section F1e and T1b for additional comments related to this requirement.	Noncompliance

#	Provision	Assessment of Status	Compliance
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted in F1d, recommendations for assessments were not integrated into supports for individuals. Teaching strategies in the SPOs reviewed did not integrate recommendations from PNMPs, BSPs, and other assessments. For this to occur, assessments will have to be completed prior to the PSP meeting and shared with other PST members. PST members will participate in integrated discussions at PSP meetings to develop a plan that addresses all preferences and supports for each individual. 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
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	For the goals and objectives identified, PSPs generally described the timeframes for completion and the staff responsible. Methods for implementation were not always adequate, as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement. Residential direct support staff were not assigned responsibility for providing support in any of the plans reviewed. For example, although health management plans were infrequently mentioned in PSP action plans, when they were, the staff responsible were listed as medical and nursing staff. Direct support professional often play a key role in implementing portions of health management plans, and notifying medical personnel of medical issues. Likewise, direct support professionals play a key role in the implementation of PBSPs and PNMPs, but PSP action plans generally listed the clinical staff as responsible. The role of direct support professionals in plan implementation should be set forth in the PSP action plans. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional	The facility had made little progress towards compliance with this item. As noted throughout the report, outcomes in the PSPs reviewed did not always adequately address supports needed by the individual to achieve the outcomes. As noted throughout other sections of this report, there is need for improvement in the development of plans to address risk for individuals, psychiatric treatment, healthcare issues, PNM needs, and behavioral support needs.	Noncompliance

#	Provision	Assessment of Status	Compliance
	at the Facility and in community settings; and	Minimal training was completed in a natural setting, such as the home or community. There had been progress made on individualizing training in group sessions during the day. Individuals observed were generally working on outcomes identified in the PSP. Vocational settings, such as the greenhouse, provided the opportunity to learn functional work skills that would easily transfer to a job in the community. Although work opportunities were not completely integrated, some individuals did have the opportunity to interact with others in the community through their work in the greenhouse, lawn crews, carwash, and other enclaves. Documentation of these important training opportunities was not found. There were certain constraints due to the fact that individuals were living at the facility rather than in the community that limited functional training opportunities. For instance, individuals did not bank in the community, or go to the pharmacy to get their medication. They did not have routine access to stores, libraries, and other facilities. They were not able to choose, join, or regularly participate in group and social activities such as church, art, and gym classes. The facility needs to continue to expand opportunities for learning to occur in natural settings and ensure that efforts are documented. The monitoring team found little documented evidence of training in the community.	
	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.	PSPs identified the person responsible for implementing service and training objectives and the frequency of implementation. PSPs also included a column to note where information should be recorded. Data collection sheets were generated for some service objectives, but not all. A person was assigned to collect data, but it was not clear what happened with the information gathered from this process in terms of making changes when an outcome was completed or when there was no progress made outside of the quarterly reviews. Training program/data collection sheets were generated for training objectives. This form included what data would be collected, the frequency of data collection, who would collect data and who would monitor data. Again, it was not clear what would happen with the information gathered from the data sheets in terms of modifying plans when needed outside of the quarterly reviews. Outcomes developed as part of risk action plans were not included in PSP outcomes. The risk action plan indicated the frequency of data collection and the person responsible for monitoring the plan, but did not indicate what data should be collected or who would collect the data. See section S of this report for further discussion on the adequacy of data collection. Additionally, see section J of this report for comments regarding the collection and	Noncompliance

#	Provision	Assessment of Status	Compliance
		review of data for psychiatric care, section K for the behavioral/psychological data collection and review, sections L and M for the collection and review of medical and nursing indicators, and, sections P and O for data collection relevant to physical and nutritional indicators.	
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. Please refer to these sections of the report regarding the coordination of services as well as section G regarding the coordination and integration of clinical 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 fully developed quality assurance system in place to effectively monitor the quality of PSPs. The monitoring team found a lack of coordinated supports and services throughout the facility. Team members from various disciplines met together to develop the PSP and discuss specific issues particularly around behavioral and health care needs. As discussed with the facility during the monitoring visit, PSTs will need to work together to develop PSPs that coordinate all services and supports.	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.	The facility POI indicated that a system was now in place to ensure PSPs were placed in individual notebooks within 30 days of the annual PSP meeting. The Home Record Clerks had been assigned responsibility. Unified Records Coordinators were performing audits of records monthly. The facility audit found a 91% compliance rate with this requirement. A sample of individual records was reviewed in various homes at the facility. Current PSPs were not available in five of 20 (25%) of the records, indicating that support staff did not have the PSPs and, therefore, the information necessary to fully implement. During the last monitoring visit, it was found that PSPs were not available in 65% of the records reviewed. The facility had implemented a plan to monitor individual records for the presence of a current plan. Although, this was an improvement from the last monitoring visit, there were still a significant number of plans not available to staff providing supports. The facility needs to develop a plan 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		clerical task. As noted throughout this report, plans were not always written to ensure that staff would know how to consistently provide all necessary supports. As a direct support staff, it would be difficult to read the PSPs as written and determine what his or her responsibilities were for the individual during the course of the 24-hour day. Plans need to clearly direct staff in providing supports and specify a schedule for when each support should be provided. The facility remained out of compliance with this requirement.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	A review of records indicated that the PST routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues. The week of the monitoring visit, numerous meetings were scheduled to discuss various incidents individuals outside of regularly scheduled quarterly and annual PST meetings. The monitoring team requested a sample of monthly and quarterly reviews from each home at the facility. A report entitled monthly review was provided for two individuals. QMRPs completed a review of health services, programmatic records, and progress on SPOs. Monthly reviews did not offer specific information of progress or lack of progress towards outcomes or address all supports. The following was found in regards to the two monthly reviews in the sample: • For Individual #115, his monthly review dated 6/15/11 was a review 2/20/11 – 4 /20/11. The QMRP noted a lack of progress on three out of five of his SPOs. The monthly review noted that the monitor was contacted for follow-up on level of assistance due to lack of progress on two of his outcomes. The monthly review did not indicate if his level of assistance was a barrier to progress. It was unknown if attempts were made, data was accurately collected, or he had refused to attend training. He was at high risk for poor oral hygiene according to his risk assessment; the monthly review did not address his oral hygiene. • The monthly review for Individual #592 for 6/12/11-7/12/11 indicated that some significant events had taken place during the month including a nursing care plan being developed for a skeletal fracture, an unusual incident on 7/7/11, and referral for alternative placement "per guardian." There were no additional comments regarding follow-up needed by the PST. The psychologist reviewed behavioral data, but noted the data summary was not reliable due to inconsistent data collection. There was no indication that this was addressed by the team. The monthly review process was now being monitored using the Monthly QMRP Review	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monitoring Form. A sample of 25 monitoring tools completed between May 2011 and August 2011 was reviewed by the monitoring team. There were few recommendations made regarding the monthly review process as a result to monitoring. It will be important to document and address trends identified through this process. It was not evident that PSTs were consistently following up on the supports and services monthly as this provision requires. Another example where it was evident the team was not following up on supports as necessary was for Individual #359. The previous communication assessment for Individual #359 recommended that speech service be requested through the school system. According to the PST, the team was not sure if he had been receiving speech services. He reported that his glasses were broken. He had not had them for over a month. The PST was not aware that he did not have his glasses. The facility will need to implement a system to monitor services and supports monthly and ensure that plans are revised and updated as necessary. When plans are revised, there needs to be a system in place to ensure that all support staff are aware of changes and new plans are being implemented as written. Monthly reviews should address the lack of implementation, lack of progress, or need for revised supports. Follow-up on issues occurring during the quarter should be documented. As the facility continues to progress toward developing person centered plans for all individuals at the facility, QDDPs 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. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues.	
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	In order to meet the Settlement Agreement requirements with regard to competency based training, QDDPs 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%) had completed the new training on PSP process entitled Supporting Visions. This was a first step in ensuring that all staff have the basic skills to use the PSP as a guide to implementing supports. As evidenced by findings throughout this report, training on the implementation of individual plans was not ensuring that plans were being implemented as written.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	The facility's POI indicated noncompliance with this requirement. The monitoring team agreed with that assessment. The QDDP director was aware of deficits in the implementation of the PSP and was providing additional training to QDDPs in monitoring for this requirement. The facility's self-assessment indicated a 75% compliance rate with this requirement. The audit process looked at initial training in implementation of the plan and updated training when plans were revised. It was unknown if observation was used by the auditors to determine competency or if this was strictly a review of training documentation. The facility will need to have a plan in place to assess competency for compliance with this provision. The monitoring team understands that additional consultative support, training, mentoring, and coaching were going to be provided by the state office over the next few months.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Of PSPs in the sample reviewed, all (100%) had been developed within the past 365 days. As noted in F2c, a sample of 20 plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. It was found that 25% 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 did not have the tools that they needed to safely and consistently support individuals. Additionally, as noted in F2d, plans were not always revised as needed. The facility was rated as being out of compliance with this provision item.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Progress had been made with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that PSPs are developed. Quality enhancement activities with regards to PSPs, however, were still in the initial stages of development and implementation (also see section E above). Positive developments included: • DADS Policy #004.V continued to address quality assurance processes to ensure PSPs were developed and implemented consistent with the provisions of the Settlement Agreement. • MSSLC was conducting a number of reviews/audits of PSPs and the PSP process, including audits using: o The Settlement Agreement Cross Referenced with ICF/MR Standards	Noncompliance

#	Provision	Assessment of Status	Compliance
		Section F: Integrated Protections, Services, Treatments and Supports audit tool; and o The Q Construction: Facilitating for Success – Qualified Mental Retardation Professional Facilitation Skills Performance Tool. o Personal Support Plan Meeting Monitoring Checklist o Monthly Review Monitoring Form o Tool to review the CLOIP discussion • The QDDP director was both attending and monitoring a sample of PSP meetings and along with reviewing a sample of PSPs using new monitoring tools. She reported that she was providing immediate feedback and training to QDDPs. An effective quality assurance system for monitoring PSPs was not fully in place at the facility.	

Recommendations:

1. Team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year (F1).

2. The QDDP director should provide QDDPs with additional technical assistance or training on group facilitation, particularly as is relates to the interdisciplinary team process (F1a).

3. The criteria for determining when a team member's attendance at a PSP meeting is required should be defined, and incorporated into the attendance database to ensure its reliability (F1b).

4. All team members will need to ensure assessments are completed updated when necessary and accessible to all team members prior to the PST meeting to facilitate adequate planning. Consideration should be given to capturing and sharing information regarding possible areas of interests while individuals are in the community (F1c).

5. A description of each person's day along with needed supports identified by assessment should be included in PSPs (F1b, F1d).

6. Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility (F1e).

7. Plans need to address obstacles to living in a less restrictive environment with specific outcomes and develop criterion for determining when teams would no longer consider the obstacle a barrier to living in the community (F1e).

8. Provide additional training to PST members on developing and implementing plans that focus on community integration (F1e, F2a).

9. Meaningful supports and services should be put into place to encourage individuals to try new things in the community. The PSTs should develop action steps that will facilitate community participation while learning skills needed in the community. Training in the community should be documented and reviewed at PST meetings (F2a1).

10. Team members need to be provided with updated training on services and supports that are now available in the community (F1e).

11. PSTs should review each individual's history of incidents and injuries, any decline in health status, or regression in skills and hold an integrated discussion regarding whether or not the facility is able to provide the best care possible for each individual (F1e).

12. Team members should be provided ongoing training and technical assistance on the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences, strengths, and needs, and to identify and overcome barriers (F2a).

13. PSTs will need to identify each person's preferences and address supports needed to assure those preferences are integrated into each individual's day (F2a1).

14. Teams should develop meaningful, measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs (F2a2).

15. PSTs 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 (F2a3).

16. Habilitation therapists should establish SPOs for interventions with measureable goals and clear consistent reporting on progress within the PSP system rather than in a separate manner (F2a2).

17. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. PSPs should clearly define direct support staff's responsibility for plan implementation (F2a4).

18. PSTs should develop outcomes that are practical and functional at the facility and in community settings (F2a5).

19. Outcomes should identify the data to be collected and/or documentation to be maintained, the frequency of data collection, the person(s) responsible for the data collection, and the person(s) responsible for the data review (F2a6).

20. Implement a monitoring system to assure PSPs are accessible to all staff providing supports to individuals at the facility (F2c).

21. Develop a process in place to revise PSPs when there is a lack of progress towards PSP outcomes or when outcomes are completed or no longer appropriate outside of schedule quarterly review meetings. Ensure all services and supports are reviewed at least monthly (F2d).

22. QDDPs should ensure that direct care staff has current information needed to support each individual safely and consistently, and that all plans are being implemented as written (F1, F2a3, F2c).

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 MSSLC facility-specific policy, Participating in Clinical Services Morning meeting, CC-41, 9/9/11 o Organizational chart, 9/1/11 o MSSLC policy lists, three policy books, July 2011 and August 2011 o List of typical meetings that occurred at MSSLC o MSSLC POI, 9/8/11 o MSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/19/11 o QAQI Council meeting minutes listed in section E above o Review of records listed in other sections of this report Interviews and Meetings Held: o Dr. Delores Erfe, M.D. o Iva Benson, Interim Facility Director o Barbara Shamblin, Bertha Allen, John Parks, Troy Miller, Polly Bumpers, Residential Unit Directors o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o QAQI Council Meeting, 9/22/11 o Morning clinical services meeting, Tuesday through Friday of onsite review week
	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. It was updated on 9/8/11. The POI provided little information on the types of activities the facility engaged in to complete the self-assessment. The medical director provided a series of helpful status updates related to each provision item. The POI did not provide information on how the self-assessment was used to determine the self-ratings of noncompliance. Several of the intermediate steps listed were associated with a measurable metric, such as compliance rates for responding to recommendations from the clinical pharmacists and consult tracking times, but it was unclear if those data was utilized in determining the self-rating. The medical director self-rated the facility as being in noncompliance with both provision items. The monitoring team agreed with

	these self-ratings. The POI also included an action plan related to provision G2. There was no action plan for G1 even though the self-rating was noncompliance. All provision items will need attention and specific plans of action in order to take appropriate steps toward compliance. Development of a definitive state policy that provides greater detail on the activities needed to achieve compliance will be beneficial to the facility.
	Summary of Monitor's Assessment: MSSLC continued to make progress with this important provision and was taking action to address it. The medical director was the lead for this provision and was aware of its importance. Evidence of integration efforts on the part of numerous disciplines was presented to the monitoring team during the conduct of this review. Notwithstanding these efforts, most areas required additional work to ensure that integration resulted in the desired clinical outcomes for the individuals. This will likely occur as the processes are refined and the facility fully embraces a culture consistent with the provision of integrated services. The strategic move to appoint the facility director as the lead for this provision should foster a greater sense of collaboration and accountability among the various disciplines. MSSLC is in need of further direction by guidance from state issued policy. Additionally, a valid and reliable monitoring tool is needed. This will require that the facility determine what it needs to measure and identify the metrics that will be utilized for measurement.

#	Provision	Assessment of Status	Compliance
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.	MSSLC made continued progress towards meeting the items of this provision. Integration of clinical services was taken seriously by the interim facility director, and by senior clinical and management staff. They were very aware of this provision and had taken actions towards achieving substantial compliance. The medical director was the facility's lead manager for this provision (as well as for provision H). DADS state office, during the week of the onsite review, directed each SSLC's facility director to become the lead for provision G. This was a good change, given the facility-wide requirements of this provision. To further assist all of the facilities in achieving substantial compliance with this provision, the monitoring teams recently presented to DADS and DOJ a listing of activities in which the SSLCs might engage that would indicate the occurrence of the provision of integrated clinical services. This list (i.e., criteria) was being reviewed by DADS and it is expected that over the next several months, this list will be finalized and can be used by each facility.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A draft DADS statewide policy had also been available for a number of months. 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 actions the facility could take to indicate that integrated clinical services were occurring. There was no facility-specific policy to address the integration of clinical service provision, however, one policy related to one activity towards this end was written and implemented regarding each day's morning clinical services meeting. The policy seemed sufficient to guide this activity. <u>Monitoring team examples</u>: 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). • The interim facility director had taken an active role in addressing the need for the provision of integrated clinical services. • The daily clinical services morning meeting was attended by the monitoring team each day during the week of the onsite review. It was led by the interim facility director and the medical director. There was good participation by the many attendees from all clinical service departments. Topics included updates from the on-call physician and psychiatrist, and updates on clinical status issues for a number of specific individuals. Discussion about an incident with one individual led to good discussion about having the psychiatrist attend the PSPA meeting following any suicidal-related behavior as well as extensive discussion about restraint. The interim facility director spoke eloquently and passionately about restraint; in particularly, she discussed the important of assessing every instance of restraint and that the staff should not become accepting of restraint usage because of the general characteristics of the population at MSSLC. • Physicians and pharmacy staff had begun to meet monthly regarding ADRs and pharmacy clinical interventions. • Habilitation and dental department staff met to plan for the use of suction toothbrushes. • QMRPs were now notifying physicians regarding the content of PSPA meetings and whether or not it would be important for them to attend. • The five residential unit directors described a number of activities that demonstrated a more integrated approach to services at MSSLC over the past	

#	Provision	Assessment of Status	Compliance
		month prior to the onsite review. These included: o Unit directors were more informed about the Settlement Agreement, participated in QAQI Council, PET meetings, and the new PIT meetings. o Training to direct care staff on oral hygiene care, aspiration precautions, making diet corrections at the table, and decreasing restraints. o Addressing missed or refused dental appointments. o Improving the dining rooms. o Doing thoughtful within-facility transitions from home to home or unit to unit. • The PNMT was recently implemented. This was a multidisciplinary group that addressed the complex health issues of individuals. At the time of the onsite review, only one assessment was completed. The meeting was attended by the director of habilitation therapies, the PCP, the physical therapist, speech and language pathologist, RN, dietician, an the OTR. The meeting was an excellent example of true interdisciplinary collaboration that intended to promote comprehensive assessments. • Improved integration was noted in the area of psychiatry within the actual clinic format. This improvement was largely due to increased participation by the other disciplines. Collaborative efforts had not expanded outside of the clinic as psychiatrists, with the exception of attending the daily clinical services meetings, rarely attended other interdisciplinary meetings. 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. • Discussions and collaborative meetings did not necessarily translate into integration of clinical services at the level of the individual. The actual care provided to individuals often lacked evidence that the health needs and risks were considered and appropriate plans implemented. • Numerous individuals required neurologic and psychiatric consultation. The facility had no adequate method of achieving integration in this area. • There was no collaborative process to address the need for pretreatment sedation. Psychiatrists did not review the comprehensive medication regimen prior the administration of oral sedation. • Assessment of the integration between psychiatry and psychology proved difficult largely because most of the psychiatrists were new to the facility. • The recent changes in psychiatry staff made determination of collaboration between psychology and psychiatry difficult. It was obvious that the quality of	

#	Provision	Assessment of Status	Compliance
		data provided from psychology to psychiatry required improvement.	
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.	As noted in the previous monitoring report, the facility appeared to be responsive to recommendations from non-facility clinicians. The facility was using the medical internal/external audit to assess a number of areas including G2. The POI indicated 61% compliance with provision item G2, but it was impossible to determine how this was calculated. Further, questions 27 and 28 were related to G2, but would need to be modified if they were to correctly assess G2. The medical department continued to maintain 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). The review of records listed in section L of this report showed that this occurred, but there were several instances among the records reviewed where consultation recommendations were not documented and followed-up.	Noncompliance

Recommendations:

1. DADS should develop and implement policy (G1 G2).
    a. The policy should include items agreed upon by the monitoring teams, DADS, and DOJ.
    b. The policy should consider including items (and possibly definitions) in the MSSLC facility-specific policy.

2. Develop facility-specific policies through the required approval process (G1).

3. Develop a system to assess whether or not integration of clinical services is occurring (i.e., self-monitoring). This will require creating measurable actions and outcomes (G1).

4. Address the items above in G1 under "Other examples indicated that more work needed to be done" (G1).

5. Consider the inclusion of a statement regarding the integration of clinical services in each individual's PSP document (G1).

6. Continue to explore the options for achieving integration of psychiatry and neurology (G1).

7. Develop a multidisciplinary review team to ensure that each individual who receives pretreatment sedation benefits from a review of the proposed interventions. The primary provider, psychiatrist, and psychologist should participate in the review (G1).

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 MSSLC facility-specific policy, Participating in Clinical Services Morning meeting, CC-41, 9/9/11 o Organizational chart, 9/1/11 o MSSLC policy lists, three policy books, July 2011 and August 2011 o List of typical meetings that occurred at MSSLC o MSSLC POI, 9/8/11 o MSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/19/11 o QAQI Council meeting minutes listed in section E above o Review of records listed in other sections of this report Interviews and Meetings Held: o Dr. Delores Erfe, M.D. o Iva Benson, Interim Facility Director o Barbara Shamblin, Bertha Allen, John Parks, Troy Miller, Polly Bumpers, Residential Unit Directors o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o QAQI Council Meeting, 9/22/11 o Morning clinical services meeting, Tuesday through Friday of onsite review week
	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. It was updated on 9/8/11. The POI provided little information on the types of activities the facility engaged in to complete the self-assessment. Instead, the medical director listed a status update related to each provision item. This information was helpful to the monitoring team in quickly determining essential intermediate steps taken along the compliance pathway. The POI did not provide information on how the self-assessment was used to determine the self-ratings of noncompliance. Several of the intermediate steps listed were associated with a measurable metric, such as compliance rates with the various assessments, but it was unclear if that data was considered.

	The medical director self-rated the facility as being in noncompliance with all seven provision items. The monitoring team agreed with these self-ratings. The POI also included an action plan related to provisions H2 and H3. The plan for provision H3 focused on hospital transfers. This provision items alludes to overall timeliness of care, not just emergency care. In order to achieve compliance with this item, the facility will need to take several additional steps as discussed in section H3. Moreover, all provision items will need attention and specific plans of action in order to take appropriate steps toward compliance. Development of a definitive state policy and clinical guidelines will be beneficial in moving towards compliance with the Settlement Agreement.
	Summary of Monitor's Assessment: During the week of the onsite visit, the monitoring team had the opportunity to meet with the medical director, interim facility director, and other facility management. While all acknowledged the importance of the provision, it was clear that attention had not been clearly directed towards these efforts. This appeared partly due to a lack of clarity on the specific requirements of the provision. The findings of noncompliance with all items in this provision were not unexpected given the lack of clarity among the facility staff on how to proceed. A draft state policy was disseminated. Although it was not yet completed, it provided some detailed guidance to the facility regarding provision H. As this provision encompasses all clinical services, it will be critical for all clinical departments to have extensive involvement with further development. It is recommended that the facility's QA department play a role in addressing this provision.

#	Provision	Assessment of Status	Compliance
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.	The state and the facilities need to determine how to proceed regarding section H across all of the SSLCs, including the determination of the detail, definition, expectations, and criteria for all of the items of this provision. Provision H refers to the minimum common elements of clinical care, that is, to the full range of clinical care and services. This includes the many different types of clinical services provided at MSSLC and as detailed in provision item G1. It is possible that a lot of the actions required for the seven items of provision H already existed in the many clinical departments at the facility. Part of the intention of provision H is to coordinate all of this information to ensure that overall, minimum common elements of clinical care are provided and managed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Because much work needed to be done, overall, it was not surprising that little progress had been made regarding all of the items of provision H. As was the case with provision G, the medical director and facility management were very aware of the importance of this provision and its components, however, they had not yet focused their attention on how to address all of the contents of the provision. Guidance from state office will be necessary. 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). Some activities had occurred at MSSLC regarding this provision item, but they had not yet done so for all of the clinical service departments as required by this provision item. Monitoring team examples: • The primary care physicians completed Annual Medical Summaries in a timely manner. Quarterly Medical Summaries were also starting to be done. This process presented an opportunity for the primary provider to review the records, results of diagnostic studies and other data and formulate a concise note that provided a snapshot of the interval health events. • The provision of preventive care and screenings was another method of ensuring the timely detection of needs. The secondary prevention afforded by the various cancer screenings was intended to detect disease in the early stages before significant morbidity occurred. Further discussion of preventive services is found in Section L1. • In addition to providing preventive treatment, physicians responded to the acute needs of individuals by conducting assessments, ordering diagnostic studies and providing treatments. Record reviews showed that follow-up of acute issues usually occurred in an appropriate manner. • The completion of the MOSES and DISCUS evaluations by the nursing staff and medical providers provided regular assessment of individuals in an effort to identify the development or presence of extrapyramidal symptoms and tardive dyskinesia. The timeliness of completion of these evaluations was an issue that required attention. • OTs, PTs, and SLPs all conducted annual assessments for individuals who received supports and services. There were interim assessments completed for	

#	Provision	Assessment of Status	Compliance
		specific problems identified and were referral-based. Assessments post hospitalization for PNM-related concerns was not noted by OT, PT and speech on a routine basis. It was of concern that documentation by all the therapists was limited to separate consults or issue-specific assessments filed in the Habilitation Therapy section of the individual record rather than readily available to all team members in relation to other issues or events as documented in the Integrated Progress Notes. There were also examples of areas that were in need of further work: • Individuals' nurses had not consistently notified the individuals' physicians in a timely manner of significant changes in the individuals' health status and needs. There were many lapses in follow-up to ensure that individuals who suffered significant changes in their health status were monitored and/or evaluated until resolution of their health changes/problems. • There was a consistent failure to implement Health Management Plans and Acute Care Plans in a timely manner. Additionally, it was noted that the plans lacked appropriate revision in response to a change in the individual's status.	
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 Integrated records and other documents reviewed demonstrated that, generally, the appropriate ICD-9 nomenclature was used. Psychiatry documentation lacked adequate detail regarding diagnostic criteria when there was a change in diagnosis, in part, due to the lack of adequate case formulations.	Noncompliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	MSSLC did not have a plan 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. Facility self-monitoring might include an item indicating whether there were any examples of interventions being clinically inappropriate and/or provided later than clinically appropriate. Although a plan to address this provision was lacking, the development of clinical guidelines will provide assistance in moving towards compliance. Clinical guidelines, for a specific disease or symptom, will provide a series of steps that include the diagnostic	Noncompliance

#	Provision	Assessment of Status	Compliance
		studies to be conducted, treatment to be provided and the assessment of the effective ness of treatment. The timelines for each of these actions should be specified. The medical director noted that the facility had improved its process and speed of instituting transfers to emergency rooms and hospitals. The data derived from the OT/PT/SLP assessments did not appear to justify the interventions implemented.	
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.	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 to assist the facility in meeting this, as well as the other, items of provision H. Valid and reliable clinical indicators had not been developed in most disciplines. The medical director reported that the nurse educator was doing some training regarding clinical indicators. This was targeted at direct care professionals so that they could recognize symptoms of common problems. There was no evidence that the goals/desired outcomes of individuals' HMPs (i.e., the indicators of efficacy of treatments and interventions) were established with input from the individuals and their caregivers, in accordance with evidence based practice, or revised to reflect the changing needs/desires of the individual and their progress/lack of progress toward the achievement of their health goals. Rather, goals/desired outcomes were the same for most health problems and not individualized, in accordance with the specific health needs and risks of the individual. With regards to the PNMPs, there were generally no measurable goals established for interventions provided. Documentation was more anecdotal in nature making tracking progress and comparing/contrasting data to describe progress over time difficult. In order to move towards substantial compliance, the facility will need to develop numerous clinical indicators, covering a wide range of health issue, inclusive of preventive care, that can be measured longitudinally.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	A plan was not in place to address this item and, therefore, this item was rated as being in noncompliance. 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). At the time of the onsite review, the health status of each individual was monitored	Noncompliance

#	Provision	Assessment of Status	Compliance
		through a series of assessments that included annual and quarterly medical and nursing assessments. Quarterly pharmacy assessments were also completed. Additional oversights such as the adverse drug reporting system contributed to the monitoring of health status. DADS Draft Policy #005 outlined expectations for development of a health status monitoring system. Monthly monitoring of numerous aspects of health care services, such as staffing, resources, and clinical indicators was the goal. These requirements effectively translated into the framework of a medical quality program by utilizing a robust mix of process and clinical indicators to assess the quality of care. As discussed in Section L, the medical department had not developed a medical quality program and the data infrastructure was not in place to support such an initiative. The databases that were developed produced reports that were easily recognized as inaccurate. It was not clear if this was due to data collection, entry, or the queries generated to produce the reports. Nonetheless, one absolute requirement for a quality program is the use of accurate data. Another vital component of the medical quality program will be the selection of the metrics for measurement or the clinical indicators. Many clinical indicators will result from the development of the clinical guidelines. The facility currently collected some data that has the potential to measure quality. The facility will need to determine what indicators of medical quality are important as well as how the indicators will be measured. Assurances of data integrity will need to be implemented.	
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.	No work had been done for this provision item, that is, 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. The development of clinical guidelines is essential to meeting this provision. The clinical guidelines, for a given disease process, will outline through a series of pathways, the diagnostics needed, the treatment options and expected outcomes (the clinical indicators). When the outcome is not met, as evidenced by a lack of improvement or resolution of the problem, the pathway and treatment options should change. This approach to the provision of evidenced-based care cannot proceed in the absence of clinical guidelines.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three	Policies, procedures, and guidelines were not in place regarding Section H and, therefore, this provision item was found to be in noncompliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.		

Recommendations:

1. State office and the facilities should work together to determine how they are going to address all of the seven items of this provision. Therefore, specific recommendations for each of the seven provision items are not presented here (H1 – H7).

2. Develop and implement policy. Specifically indicate in the policy how it addresses each of the seven provision items of provision H (H1 – H7).

3. Ensure that all clinical services are addressed by the facility, not only medical activities (H1 – H7).

4. 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 (H1 – H7).

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:** <u>Documents Reviewed</u>: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Integrated Risk Rating Form dated 12/20/10 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 Aspiration Pneumonia/Enteral Nutrition Evaluation Form 12/29/10 o Aspiration Triggers Data Sheet o MSSLC POI for Section I o MSSLC Section I Presentation Book o List of individuals seen in the ER or hospitalized since 3/1/11 o List of individuals with fractures or sutures since 3/1/11 o List of individuals with pneumonia incidents in the past 12 months o List of individuals at risk for respiratory issues o List of individuals at risk for contractures o List of individuals at risk for choking (not provided) o List of individuals diagnosed with dysphagia o List of individuals at risk for GERD (not provided) o List of individuals at risk for aspiration o List of individuals at risk for weight issues o List of individuals at risk for falls (not provided) o List of individuals at risk for skin breakdown o List of individuals at risk for challenging behaviors o List of individuals at risk for dehydration o List of individuals diagnosed with diabetes o List of individuals at risk for seizures o List of individuals at risk for osteoporosis o List of individuals at risk for constipation o List of individuals diagnosed with pica o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals requiring mealtime assistance o List of individuals who have pain, including chronic and acute o List of individuals with poor oral hygiene o List of individuals considered missing or absent without leave o List of individuals required to have one-to-one staffing levels o List of 10 individuals with the most injuries since the last review

	o List of 10 individuals causing the most injuries to peers for the past six months o List of top ten individuals causing peer injuries for the past six months. o List of Incidents and Injuries since 3/1/11 o PSPs and relevant assessments for determining risk: • Individual #461, Individual #108, Individual #244, Individual #592, Individual #570, Individual #521, Individual #42, Individual #359, Individual #227, Individual #39, Individual #331, Individual #242, Individual #115, Individual #483, Individual #588, Individual #319, Individual #376, Individual #6, Individual #422, Individual #264, and Individual #126 <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Charlotte Kimmel, PhD, Director of Psychology o Valerie McGuire, QDDP Director o Charles Bratcher, Quality Services Director o Justin Vest, Risk Officer o Pat Samuels, Incident Management Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Daily Incident Management Review Team Meeting 9/19/11 o Longhorn Daily Unit Meeting 9/21/11 o Restraint Reduction Committee Meeting 9/22/11 o Human Rights Committee Meeting 9/20/11 o Risk discussion meeting for Individual #524 o PSPA meeting for Individual #37 o Quarterly PSP meeting for Individual #128 o Annual PSP meetings for Individual #360 and Individual #123
	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. It was updated on 9/8/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding how the facility carried out the mandate (e.g., QDDPs were inserviced regarding the process to refer individuals to the PNMT and behavior committee). The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item.

	The facility assigned a noncompliance rating to each of the three provision items in section I. 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 monitoring team was in agreement with these self-ratings. It was unclear from a review of the POI how MSSLC came to this self-rating.
	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: • 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 had been implemented to address aspiration pneumonia. A tool had been developed to identify individuals at risk for aspiration. 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. A number of activities in regards to the risk process had taken place since the last monitoring visit. • The State Office had provided onsite training on the risk process at MSSLC in July 2011. • QDDPs were trained regarding the process of referring individuals to the PNMT and behavior committee. • The QDDP director and Assistant Director had provided training to PSTs on accurately determining risk ratings and developing action plans. • The facility implemented an audit process using the Section I: At Risk Settlement Agreement Cross Referenced with ICF-MR Standards tool. As noted throughout Section I, the monitoring team did not find that PSTs were accurately identifying risk for individuals, even with the new process. 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.

#	Provision	Assessment of Status	Compliance
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 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 beginning in February 2011. 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. Each was to be rated according to how many risk indicators applied to the individual's case. A risk level of high, moderate, or low was to be assigned for each category. The facility captured data in a number of ways that should have been useful to identify risks for particular individuals, but it was not evident that the data were always being used to identify risks. For instance, 60 individuals had been diagnosed with dysphagia. Only 12 (20%) of those individuals were identified as being at high or medium risk for choking. The facility had identified a target list of individuals at risk for aspiration. Eleven individuals at the facility had been identified as high risk for aspiration and 82 were rated as medium risk. Nine individuals (11%) at medium risk did not have a plan in place to address the risk. A list of all individuals diagnosed with pneumonia at the facility indicated that six individuals had been hospitalized due to pneumonia/aspiration pneumonia since 3/1/11. All individuals who had incidence of pneumonia were assigned a high or medium risk rating. As noted in I3, not all individuals at risk had a plan in place to address that risk. Members of the monitoring team attended meetings to address aspiration. There was a noticeable lack of participation by many team members who should have added to the discussion. It could have been due to the monitoring team's presence at the meeting, but was more likely due to PST members being unclear about the risk identification process and their role in the process. The monitoring team met with the PSTs for Individual #524 during the review week to observe and discuss how the teams assigned risk ratings, as well as to demonstrate the type of interdisciplinary discussion that could occur during PST meetings. The monitoring team appreciated the PST's willingness to conduct this type of discussion with the monitoring team. Monitoring team comments and suggestions from this discussion are included throughout section I of this report, including a detailed description of a review of her at-risk information in her record (see I2 below).	Noncompliance

#	Provision	Assessment of Status	Compliance
		Observation of annual PST meetings scheduled the week of the review showed that PSTs 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. QDDPs were responsible for attending meetings and facilitating the risk discussion. At meetings observed, the process appeared to be similar to the process that Health Status Teams were using during previous onsite reviews. The team briefly read over the indicators for each risk and corresponding disciplines assigned the rating based on the state guidelines. There was little integrated discussion and clinical indicators were not considered when determining health risk ratings. Comments from the monitoring team regarding risk discussions are summarized below: • Guidelines for determining risk ratings should only be used as a guide. Teams should discuss other factors that may not be included in the guidelines. • The interrelatedness of risk factors should be considered and discussed in an interdisciplinary fashion. • Teams should be thinking about characteristics that put an individual at risk (i.e., statistical at risk) rather than just reviewing their personal history of experiencing the identified problem (e.g., someone might be at high risk for aspiration even if he or she never had the problem). • Once the individual has a diagnosis, it is now a medical condition that needs to be treated, but the team needs to continue to consider its impact on other areas of risk. For example, an individual with a diagnosis of osteoporosis is no longer considered at risk for osteoporosis (i.e., she has osteoporosis), but may be at risk for fractures. • Teams need to consistently gather and analyze data regarding health and behavioral indicators (e.g., changes in medication, results from lab work, incidents of SIB, engagement levels) • Both short and long term outcomes and specific action step for achieving those outcomes need to be developed. • Progress towards outcomes needs to be monitored, and information needs to be shared with all team members frequently, so that plans can be revised if progress is not being made or regression occurs. A sample of PSPs and the facility risk rating list were reviewed to determine if risks were being properly identified and addressed by PSTs. The following are examples where risks were not appropriately identified in documents reviewed. ▪ Individual #461 had a number of risks identified related to his diagnosis of diabetes and challenging behaviors, including refusals to adhere to his ADA diet. Though noted in his PSP, the PSP did not describe signs and symptoms that direct support staff needed to monitor or how supports should be provided to	

#	Provision	Assessment of Status	Compliance
		minimize his risks. Not all healthcare risks were adequately identified in his PSP. He took a number of medications with side effects that should be monitored and his dental assessment noted that he had periodontal disease that if not treated aggressively could lead to infection and possibly aspiration. The dietician did not attend his annual PSP meeting. Her input would have been critical in developing adequate supports related to his diabetes. ▪ Individual #108 was rated as being at risk for osteoporosis, polypharmacy, challenging behaviors, falls, and fractures. Her PSP accurately identified her risk areas, but did not describe supports needed to monitor her healthcare in order to minimize her risk. Her risk action plan included action steps to reduce risk, but was not specific enough to direct staff in carrying out the plan. For example, an action step to address polypharmacy was "to observe for signs of adverse reactions – signs/symptoms". The plan did not indicate what signs and symptoms of an adverse reaction staff should monitor and report. ▪ Similarly, Individual #284 was considered by his PST to be at high risk for polypharmacy. He was taking a number of psychotropic medications. His PSP documented his risk, but assigned responsibility for monitoring to nursing and psychiatry. Direct support staff were not given responsibility or information regarding monitoring his risk. ▪ A number of additional examples are listed in section M5. The facility was not yet in compliance with this provision item. The facility needs to ensure that present risk assignments are reviewed for accuracy, adequate plans are in place to address all risks, and all staff are trained on plans to minimize and monitor risks.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The new At Risk policy required that when an individual was identified as being at risk, the PST should meet to develop a plan. The PST or PCP may refer to either the Physical Nutritional Management Team (PNMT) for health risk, or to the Behavior Support Committee (BSC) for behavioral risk, for those individuals at high risk who are not stable and for whom the team needs assistance developing a plan. The PNMT or BSC was then required to begin assessment within five working days 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. Additionally, as noted in section F of this report, the facility did not have an effective plan for monitoring and revising supports as needed. QDDP monthly reviews for Individual #39 and Individual #115 were reviewed by the monitoring team. The QDDP monthly reviews did not reference risk areas and risk action plans were not reviewed by the QDDP. There was a newly formed At-Risk Committee/Team. It was the role/responsibility of	Noncompliance

#	Provision	Assessment of Status	Compliance
		this team to assist individuals' PSTs with appropriately applying the at-risk policy, procedures, and guidelines to evaluate individuals' health risks and respond in timely way to changes in at-risk individuals' conditions. • Individual #524 was an example of an "at-risk individual." In April 2011, her PST determined that she was at high risk for fluid imbalance, hypothermia, osteoporosis, polypharmacy/side effects, seizures, and urinary tract infections. Over the past several months, Individual #524 was hospitalized several times for treatment of hypothermia, urinary tract infection, possible pneumonia, hypotension, and possible early septicemia. In addition, she underwent a modified barium swallow study that showed dysphagia. Notwithstanding these negative health outcomes and persistent problems managing and reducing Individual #524's health problems and risks, her nursing assessment noted, "Done well this quarter." It was apparent that the nurse's findings during his/her assessment – hospitalization, hypothermia, persistent infection, frequent us of multiple antibiotics for multiple drug resistant infections, dysphagia diagnosis, lower extremity edema, continued episodes of weakness, etc. – failed to accurately inform the conclusions of his/her assessment of Individual #524's health status and risks. One of the most important aspects of a health risk assessment process is that it effectively prevents the preventable and reduces the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. 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	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. The new policy required 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. According to data provided to the monitoring team, of the 93 individuals rated at high or medium risk for aspiration, nine (10%) did not have a care plan in place to address the risk. There were similar findings in data provided to the monitoring team regarding the lack of care plans for individuals identified as being at risk in a number of areas as evidenced by the chart below.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.		

High Risk Category	Number of Individuals Rated as High Risk	Number of Individuals Rated as Medium Risk	Individuals with Plan in Place to Address Risk/Percentage of Total
Aspiration	11	82	84/90%
Respiratory	7	27	24/71%
GERD	Not provided		Not provided
Choking	7	27	24/71%
Dehydration	4	23	21/78%
Weight	6	92	85/87%
Skin Integrity	8	71	65/82%
Constipation	2	75	67/87%
Seizures	8	40	46/96%
Osteoporosis	34	77	102/92%
Dental	2	51	30/57%
Metabolic Syndrome	1	9	9/90%

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 behavioral risk for the individuals who they were supporting, but were not familiar with health care risks. As noted throughout this report, intervention plans were often not carried out as written, therefore, individuals remained at risk.

Risk action plans in the sample referred the reader to HCP or BSP for specific strategies to address risks. The monitoring team requested PSPs for a sample of 22 individuals. HCPs were not submitted with any of the PSPs. This supported the monitoring team's impression that the overall philosophy at the facility was that healthcare was not an integral part of supports provided to individuals. PSPs should include information regarding supports and services necessary to minimize risks for individuals. Information should be clearly written and include clinical indicators to ensure consistent implementation and monitoring.

During observations in the individuals' homes by the monitoring team, it was noted that some PSPs, HCPs, PNMPs and other support plans were missing from individual records or not accessible. Thus, direct support staff did not have current information regarding risks available to them. Additionally, as noted in Section F, PSPs did not assign direct support staff responsibility for monitoring health risks.

Recommendations:

1. 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. QDDPs and PSP Coordinators should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process (I1).

2. Ensure that risk rating accurately reflect risks identified through the assessment process (I1).

3. All health issues should be addressed in PSPs and direct care staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues and when to seek medical support (I1, I2, I3).

4. Ensure PSTs are monitoring progress on health and behavioral outcomes and plans are revised when necessary (12).

5. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk (I2).

6. 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 (I2, I3).

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 Any policies, procedures and/or other documents addressing the use of pretreatment sedation medication o For the past six months, a list of individuals who have received pretreatment sedation medication or TIVA for medical or dental procedures o For the last 10 individuals participating in psychiatry clinic who required medical/dental pretreatment sedation, a copy of the doctor's order, nurses notes, psychiatry notes associated with the incident, documentation of any PST meeting associated with the incident o Ten examples of documentation of psychiatric consultation regarding pretreatment sedation for dental or medical clinic o List of all individuals with medical/dental desensitization plans and date of implementation o Ten examples of desensitization plans (five for dental and five for medical) o Any auditing/monitoring data and/or reports addressing the pretreatment sedation medication. o A description of any current process by which individuals receiving pretreatment sedation are evaluated for any needed mental health services beyond desensitization protocols o Individuals prescribed psychotropic/psychiatric medication, and for each individual: name of individual; name of prescribing psychiatrist; residence/home; psychiatric Diagnoses inclusive of Axis I, Axis II, and Axis III; medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration); frequency of clinical contact (note the dates the individual was seen in the psychiatric clinic for the past six months and the purpose of this contact, for example: comprehensive psychiatric assessment, quarterly medication review, or emergency psychiatric assessment); date of the last annual BSP review; date of the last annual PSP review o A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use o A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use o A list of individuals diagnosed with tardive dyskinesia, including the name of the physician who is monitoring this condition, and the date and result of the most recent monitoring scale utilized o Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS scores, with dates of completion for the last six months o Documentation of in-service training for facility nursing staff regarding administration of MOSES and DISCUS examinations o Ten examples of MOSES and DISCUS examination for 10 different individuals, including the psychiatrist's progress note for the psychiatry clinic following completion of the MOSES and DISCUS examinations o A separate list of individuals being prescribed each of the following: anti-epileptic medication

	being used as a psychotropic medication in the absence of a seizure disorder; lithium; tricyclic antidepressants; trazadone; beta blockers being used as a psychotropic medication; Clozaril/Clozapine; Mellaril; Reglan o List of new facility admissions for the previous six months and whether a REISS screen was completed o Spreadsheet of all individuals (both new admissions and existing residents) who have had a REISS screen completed in the previous 12 months. o For five individuals enrolled in psychiatric clinic who were most recently admitted to the facility: individual Information Sheet; Consent Section for psychotropic medication; personal Support Plan, and PSP addendums; Behavioral Support Plan; Human Rights Committee review of Behavioral Support Plan; Restraint Checklists for the previous six months; Annual Medical Summary; Quarterly Medical Review; Hospital section for the previous six months; X-ray, laboratory examinations and electrocardiogram for the previous six months.; Comprehensive psychiatric evaluation; Psychiatry clinic notes for the previous six months; MOSES/DISCUS examinations for the previous six months; Pharmacy Quarterly Drug Regimen Review for the previous six months; Consult section; Physician's orders for the previous six months; Integrated progress notes for the previous six months; Comprehensive Nursing Assessment; Dental Section including desensitization plan if available o A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend, including any information that is routinely collected concerning the Psychiatrists' attendance at the PST, PSP, PSPA, and BSP meetings. o A list and copy of all forms used by the psychiatrists o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o A list of all psychiatrists including board status; with indication who has been designated as the facility's lead psychiatrist o CVs of all psychiatrists who work in psychiatry, including any special training such as forensics, disabilities, etc. o Overview of psychiatrist's weekly schedule o Description of administrative support offered to the psychiatrists o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility o A list of continuing medical education activities attended by medical and psychiatry staff o A list of educational lectures and in-service training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who have a diagnosis of seizure disorder o For the past six months, minutes from the committee that addresses polypharmacy o Any quality assurance documentation regarding facility polypharmacy o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy

	o Facility-wide data regarding polypharmacy, including intra-class polypharmacy. o For the last 10 newly prescribed psychotropic medications, Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger who are receiving psychotropic medication. o Name of every individual assigned to psychiatry clinic who has had a psychiatric assessment per Appendix B with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission o Ten comprehensive psychiatric evaluations per Appendix B performed in the previous six months o Documentation of psychiatry attendance at PSP, PSPA, BSP, or PST meetings o A list of individuals requiring chemical restraint and/or protective supports in the last six months Documents Requested Onsite: o Copy of the section J presentation book o Minutes from the clinical services meeting, 9/20/11 o All data presented, doctor's orders, and Dr. Creager's documentation for psychiatry clinic, 9/19/11 regarding Individual #457, Individual #284, and Individual #169 o All data presented, doctor's orders, and Dr. Rao's documentation for psychiatry clinic 9/20/11 regarding Individual #386, Individual #539, and Individual #320 o All data presented, doctor's orders, and Dr. Brown's recommendations for psychiatry clinic 9/21/11 regarding Individual #381, Individual #276, Individual #455, and Individual #339. o All data presented, doctor's orders, and Dr. Swicegood's documentation for psychiatry clinic 9/22/11 regarding Individual #436, Individual #244, and Individual #13 o These following documents for all of the individuals listed in the above four bullets and for Individual #560, Individual #150, Individual #508, Individual #373, Individual #567, and Individual #410 • Identifying data sheet • Annual Medical Summary and Physical Exam • Active Current Diagnoses Sheet • X-ray/Lab section (for the last six months) • Psychiatry section (for the last six months) • Neurology section (for the past year) • MOSES/DISCUS results (for the last six months) • Pharmacy section (for the last six months) • Consent section for psychotropic medication • Integrated progress notes (for the last six months) • Consent section (for psychotropic medications) • PSP and PSP addendums/reviews/annual (for the past six months)

	• Behavior Support Plan Interviews and Meetings Held: o Iva Benson, Interim Director o Dolores Erfe, M.D., Medical Director o Charlotte M. Kimmel, Ph.D., Director of Psychology o John Sponenberg, D.D.S., facility dentist o Margaret Michelle Boutte, M.A. and Erin Baust, psychiatric assistants o Group meeting with the Medical Director and the four facility psychiatrists: Kendall P. Brown, M.D., Gregory B. Creager, M.D., Madhu Rao, M.D., and Erica Swicegood, M.D. Observations Conducted: o Meeting to update the monitoring team regarding Individual #560 o Psychiatry clinic conducted by Gregory B. Creager, M.D. o Psychiatry clinic conducted by Madhu Rao, M.D. o Psychiatry clinic conducted by Kendall P. Brown, M.D. o Psychiatry clinic conducted by Erica Swicegood, M.D. o Behavior Therapy Committee (BTC) meeting o Clinical Services meeting 9/20/11 o Integrated Risk Meeting 9/20/11 for Individual #524 o Pharmacy and Therapeutics (P&T) Committee Meeting o Physicians' working lunch including primary care and psychiatric physicians o Medical Review Committee meeting
	Facility Self-Assessment: MSSLC submitted its self-assessment, the Plan of Improvement, dated 9/8/11. In addition, during the onsite review, the monitoring team reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. The facility did not have a lead psychiatrist. Therefore, the medical director provided the update for section J to the monitoring team. In the POI comments section of each item of the provision, there was a summary about what tasks were completed and/or the status of each provision item. The medical director self-rated the facility as being in substantial compliance with three provision items J1, J7, and J11. The monitoring team only agreed with one of these self-ratings regarding provision J1. The monitoring team's review was based on observation, staff interview, and document review. The facility will need to engage in similar activities in order to conduct an adequate self-assessment. In discussions with the medical director and the facility psychiatrists, the need for improved integration was noted. Most provision items in this section rely on collaboration with other disciplines.

	The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). Some of the actions were relevant towards achieving substantial compliance, but the facility will need to utilize a psychiatrist for the "responsible person" for some of the identified action steps, such as providing competency- based training to the other facility psychiatrists. The medical director has been forthcoming in her efforts to address some of the requirements of this section while being clear that her specialty does not include the field of psychiatry. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation, but a timeline that will indicate the stable and regular implementation of each of these actions. The facility was approaching compliance in provision J5. In other areas improvement was apparent, however, additional systems must be developed. The facility will benefit from the eventual development of a self-monitoring tool or a peer review process for this provision of the Settlement Agreement.
	Summary of Monitor's Assessment: Although psychiatry consultations were occurring, MSSLC was found to be in noncompliance with all of the items in this provision of the Settlement Agreement, except for provision item J1. The psychiatry department at MSSLC had seen some improvement with designated space provided for the clinic, and administrative assistance in the form of two psychiatric assistants. These improvements resulted in positive changes in the process of psychiatry clinic. The clinic was more organized in that the individual and staff were in attendance at clinic, the psychiatrist received clinical information during clinic, and discussions regarding the individuals were more detailed. Further, revision concerning documentation issues via psychiatry should occur and will be discussed throughout this section. While psychiatry was interacting with psychology on some levels, there were marked deficits in the interaction. It was apparent that some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, collaboration regarding case formulation). The physician was not provided appropriate data in order to make decisions regarding pharmacology in an objective manner, and per a review of records, made medication additions or adjustments in the absence of data regarding specific clinical indicators. The staff from each discipline were aware of the challenges and the need for increased structure and integration, however, they were also aware of the frequent psychiatric staff turnover and history of a lack of consistent clinical resources in psychiatry, which did not lend itself to close collaboration. The facility achieved substantial compliance in J1 and was close to achieving a compliance rating in J5, however, in other areas, while isolated improvements were seen, the facility staff must create a system for

	the provision of psychiatric services. Approaching section J to accomplish a comprehensive, collaborative, integrated psychiatric subspecialty service to the individual and other disciplines is required.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	MSSLC will continue to provide services for minors. Ernest A. Kendrick, M.D., P.A., a board certified Forensic, General, and Child and Adolescent psychiatrist by the American Board of Psychiatry and Neurology, signed a contract 5/16/11 to provide consulting psychiatric services for MSSLC via phone. Dr. Kendrick provided consultation services to MSSLC in recent years. Upon review of his CV, the specific dates of Dr. Kendrick's employment at MSSLC were not listed. Dr. Kendrick noted that he completed a residency in psychiatry (1978-1982) and in child psychiatry (1982-1984) at Baylor College of Medicine and Affiliated Hospitals. Regarding education, there was no listing of Dr. Kendrick completing a forensic residency. Dr. Kendrick was not present at MSSLC for this site visit. The monitoring team informed the medical director that it would be necessary for Dr. Kendrick to routinely review the identified individual's care with the general psychiatric staff particularly involving youth under the age of 14, and/or prescribed polypharmacy with complex psychiatric conditions, and/or involved in the judicial system. The monitoring team recommended that interaction with the individual and psychiatric staff occur onsite at the facility and/or via telemedicine consultation as opposed to all contact being performed by phone with the child and forensic psychiatrist. The need for consultation regarding child psychiatry services was why MSSLC was rated as being in noncompliance in the previous monitoring report. The addition of Dr. Kendrick's consultation met that need, however, occasional onsite consultation is required if the facility is to maintain substantial compliance with this provision item. 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 training in geriatric psychiatry in 2006. In regards to prior experience treating individuals with developmental disability, Dr. Brown noted that he had residency rotations learning about treating those with developmental disability during both his adult and geriatric psychiatry training. Dr. Brown also listed prior experience with caring for individuals with developmental disability from 2009 to 2010 in Behar and Dallas County. Dr. Brown was the only remaining psychiatric staff since the last monitoring review at MSSLC. Gregory B. Creager, M.D. completed a psychiatric residency at Johns Hopkins in 1997 that included a six month elective with the Johns Hopkins Neuropsychiatry and Memory group. He was board certified in Psychiatry by the American Board of Psychiatry and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Neurology. In regards to prior experience treating individuals with developmental disabilities, Dr. Creager provided psychiatric services to residents of a group home from 2000 to 2002. Additionally, Dr. Creager has periodically provided treatment to those with developmental disability requiring inpatient psychiatric treatment. Madhu Rao, M.D. re-certified in general psychiatry in 2006. She completed her psychiatry residency at Griffin Memorial and University of Oklahoma in 1986. Dr. Rao's CV noted board certification in general psychiatry in 1996. She treated children and adolescents for 25 years with experience of providing care for several individuals with developmental disabilities. Three of the four psychiatrists providing services at the facility were board certified in adult psychiatry by the American Board of Psychiatry and Neurology. Erica Swicegood, M.D. was board eligible in adult psychiatry. She completed her residency at John Peter Smith Hospital 6/30/11. Dr. Swicegood recently took the American Board of Psychiatry and Neurology examination. Dr. Swicegood was a critical care nurse (1999-2005) prior to attending medical school. She did not cite any previous experience working specifically with individuals with developmental disabilities. Dr. Swicegood noted that she had treated children and individuals with a variety of ailments (e.g., overdose, multi-system organ failure, and trauma). Based on the qualifications of the psychiatrists, this item was rated as being in substantial compliance.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Per interviews with the two full time psychiatric assistants that coordinated the psychiatrists' schedule, individuals were seen in clinic a minimum of once per quarter for their quarterly medication review. There were concerns regarding the consistency of psychiatric staffing. Since last review three psychiatrists resigned (see J5 below) At MSSLC, 259 of the 391 individuals received psychotropic medications at the time of this onsite review. Since last review, the medical director and administrative staff designated the former infirmary area as the location for all psychiatric clinics. The involvement of the psychiatric assistants and an identified location for the psychiatric examination resulted in a reduction of a total percentage of "no shows." For example, in May 2011, prior to the move, 28 out of 154 individuals (18%) were not available for their appointment with the psychiatrist. The communication between the psychiatric assistants with the PST regarding date, time, and location of the clinic, enhanced attendance in August 2011 and as a result only nine individuals out of 161 (6%) were not present for the appointment	Noncompliance

#	Provision	Assessment of Status	Compliance
		with the psychiatrist. Further, the new location provided an adequate work area for the PST to review records, discuss data, write progress notes, and allow the meeting and interview with the individual to occur in a comfortable setting. During the previous visit, clinics were held in various sites across the campus, in small uncomfortable record rooms, and during conflicting time periods for staff. A review of a sample of 20 records revealed varying quality in documentation for the psychiatric reviews. The handwritten notes were frequently not legible. Three types of psychiatric consultation documentation were found across the sampled records: • an initial psychiatric evaluation as outlined per Appendix B (if completed), • a quarterly psychotropic medication review written on a specific form, and • follow-up psychiatric consultations written in the integrated progress notes. Although this was a good attempt by the facility to streamline the documentation, it led to some unintended problems, including confusion for psychiatrists and the possible conducting of unnecessary meetings. For example, if a regular follow-up consultation was conducted, there would appear to be no reason to meet to hold a quarterly (if there were no new issues to discuss). That is, if an individual had been seen recently for a follow-up visit, and the quarterly was due shortly thereafter, the PST was required to again meet in order to complete the Quarterly Psychotropic Medication Review. The monitoring team encouraged the psychiatric staff to reconsider this process. Further, if information was written in the IPNs, it may or may not be evident and available to a new psychiatrist who had taken on, or was temporarily covering, the case. The following comments are from a review of the record of Individual #381 and exemplify typical problems with the process used for evaluation and diagnosis, and the assignment of clinically justifiable and accurate diagnoses: • The most recent medication review was dated 9/21/11. The psychiatrist wrote a handwritten entry on the Quarterly Psychotropic Medication Review Form, yet required additional space to complete the consultation, therefore, placing the rest of the information in the IPN. The documentation on the QPMR form did not direct the reader to refer to the IPN for continuation, even though it included important content in the SOAP format. The handwriting of the psychiatrist was difficult to read. The monitoring team encouraged the psychiatrists at MSSLC to reconsider the process used for the evaluation and treatment recommendations because this design did not adequately address the necessary documentation required for this provision. • A diagnosis of Impulse Control D/O, NOS, Fetishism, Pedophilia secondary to closed head injury history was assigned. There were no detailed descriptions of the justification for the use of the specific psychopharmacological agents	

#	Provision	Assessment of Status	Compliance
		outlined in the QPMR or IPN dated 9/21/11, nor evaluation and diagnosis in a clinically justifiable manner as required by this provision item. The psychiatrist did not summarize findings in an updated diagnostic formulation or explain the rationale for the selection of three medications in the quarterly review. Plan noted "(1) Quantify E & T goals: improve resolution, (2) Improve monitoring process, (3) RTC 4-6 weeks with possible (illegible)." • There were no detailed descriptions of the justification for the use of specific psychopharmacologic agents. For example, this individual was prescribed three medications (e.g., Divalproex ER 500 mg/day, Quetiapine 600 mg/day, and Sertraline 150 mg/day). The individual's polypharmacy regimen could potentially lead to side effects inclusive of drug-drug interactions. Justification for polypharmacy was "closed head" with a couple of other words that were not legible. • Other notation included diagnosis of Impulse Control Disorder. This individual remained on enhanced supervision. The psychiatrist noted that he exhibited SIB (i.e., slapped his face and bit his arm particularly when found with garments), however, there were not adequate clinical indicators identified and associated with the diagnosis to determine medication efficacy. • The psychiatrist appropriately outlined that he was experiencing changes in his medical status including right sided pain, rectal burning, elevated WBCs, and hyponatremia, and that he had returned from undergoing an ultrasound examination on this date with recommendations to F/U with the PCP. • The monitoring team observed this individual's QPMR meeting. The PST (including the individual, supervising psychologist, QMRP, nursing staff, and direct care professional) were present and met for at least 40 minutes yet was only designated a 30 minute interval to conduct the meeting. It was apparent that at least 40 minutes was required to complete the quarterly review. The psychiatrist expressed frustration to the monitoring team regarding the evaluation process presently arranged by the facility, such as not being given adequate time slots for the discussion, review of the information, and completion of documentation. • The documentation in the QPMR did not correspond with DSM-IV-TR criteria for a diagnosis of Impulse Control D/O, NOS, Fetishism, Pedophilia secondary to closed head injury history. Information provided by staff to the psychiatrist during the psychiatric review of Individual #381 did not address data relevant to these diagnoses. Therefore, it was not reliable for determining reduction of clinical indicators with psychotropic medication. The psychiatrist recommended consideration of an increase of the SSRI dose (on the QPMR form, not in the continued SOAP/IPN note) and did not document intended rationale for the recommendation. Documentation noted in the quarterly psychiatric review did	

#	Provision	Assessment of Status	Compliance
		not discuss specific diagnostic criteria for the diagnoses or identify clinical indicators associated with assigned diagnoses prior to the dosage change recommendation. • It was also confusing to the monitoring team that both the Yes and No side effects boxes for both the DISCUS and the MOSES were checked. • During the meeting, Individual #381 yawned so frequently that the monitoring team inquired if pretreatment sedation had been administered (for the ultrasound examination that occurred prior to the psychiatric appointment). This presentation of frequent yawning and tired appearance was not noted in the mental status examination completed by the psychiatrist. As illustrated by the example above, the case formulations for quarterly and/or follow-up examinations were either nonexistent, or were brief and incomplete. A case formulation should provide information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. Further, the facility did not utilize an organized system to manage and track diagnoses and diagnostic updates. For example, the psychiatric assistants maintained a database to track these elements, yet oftentimes, the database were not updated in a timely manner and the individual's record did not match the current diagnoses assigned by the psychiatrist and PST. The monitoring team had difficulty determining the current diagnoses per record review due to discrepancy noted in regards to the psychiatric diagnoses across different disciplines' evaluations (e.g., physician's annual medical review, PSP, PBSP). It is hoped that increased clinical consultation time will allow for improvements in overall quality of the clinical interaction and documentation thereof. The facility could consider quality assurance monitoring or the implementation of a peer review process.	
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	Per this provision item, individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). In the sample of 20 records reviewed, all 20 individuals prescribed medication had a PBSP on file. The details of the content of the PBSPs are discussed in section K. There was no indication that psychotropic medications were being used as punishment, for the convenience of staff, or as a substitute for a treatment program (however, there were problems in the quality of the PBSPs noted in section K) . Per the facility plan of improvement, noncompliance was the rating for this provision item because of the need	Noncompliance

#	Provision	Assessment of Status	Compliance
	hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	for "further cooperation between psychiatry and psychology in formulating a cohesive diagnosis and formulating treatment plans." While the records reviewed for individuals prescribed medication had diagnoses noted in the record, there were concerns regarding the justification and case formulation for specific diagnoses as well as the lack of clinical indicators identified for psychotropic medications. It will be important for collaboration to occur between psychology and psychiatry to formulate a cohesive differential diagnoses and case formulation, and to jointly determine clinical indicators. In this process, the PST will, it is hoped, generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and discuss strategies to reduce the use of emergency medications. It was also imperative that this information is documented in the individual's record in a timely manner. <u>Emergency use of psychotropic medications</u>: The monitoring team was provided two different lists regarding utilization of chemical restraints (some of the reports provided per the psychiatry staff did not note a date of the report). The Chemical Restraint Clinical Review for July 2011 to September of 2011 listed seven instances of individuals receiving a chemical restraint. The summary should have included only five because administration of Diphenhydramine and/or Benztropine for Extrapyramidal Side Effects (EPS) should not be considered a chemical restraint. EPS was identified for two separate individuals in the report (Individual #588 and Individual #207). Therefore, there were a total of five incidents involving three different individuals documented in the July 2011 to September, 2011 quarter. One of these individuals received three chemical restraints (Individual #491 on 8/20/11, 9/2/11, and 9/13/11). The list provided by psychiatry regarding individuals requiring chemical restraint in the <u>six</u> months prior to the quarterly report above, listed 10 incidents with dates of incidents ranging anywhere from 2/18/11 to 7/21/11. These 10 incidents involved seven different individuals with one receiving three of the chemical restraints (Individual #406 twice on 3/1/11 and once on 5/24/11). The data provided to the monitoring team regarding emergency use of psychotropic medication were inconsistent and, therefore, somewhat suspect, making it difficult to determine if progress was occurring in this area. For example, two separate documents did not capture the same information though it appeared they were reporting on the same information, such as the names of individuals that received chemical restraints. Additionally, during the onsite review, MSSLC staff presented information regarding Individual #560 to the monitoring team (e.g., administered a chemical restraint	

#	Provision	Assessment of Status	Compliance
		5/31/11). The Chemical Restraint Clinical Review dated April 2011 to June, 2011 did not include Individual #560 on the list that was provided to the monitoring team. A review of the record of Individual #560 revealed that: • This individual received a chemical restraint 5/31/11. Despite Individual #560 receiving a restrictive intervention (information that should be captured as part of the facility's QA program), the Chemical Restraint Clinical Review dated April 2011 to June 2011 did not include Individual #560 on the list that was provided to the monitoring team. Upon further review, the PSP dated 2/24/11 did not include the psychiatrist's signature and noted that Individual #560 received Depakote ER, Lexapro, and Risperidone for Schizoaffective Disorder, Bipolar Type. The absence of the psychiatrist in the PSP meeting resulted in a missed opportunity to foster strategies to reduce the use of emergency medication. The monitoring team reviewed information regarding numerous PSPAs thereafter and, at that point, there was integration of the psychiatrist with the PST as the individual began to decompensate. For example, PSP addendum dated 5/9/11 noted the psychiatrist, Dr. Eileen Farber, was in attendance to address the issue of "medication change." The psychiatrist informed the PST "there are three injectable meds…the only one most suitable…is Zyprexa…help with his mood…appetite." The team agreed to the medication change. • The PBSP was signed by PST members 6/20/11. The signature of the physician (only for PBSPs that included psychoactive medications) was not legible, but there was "psych" written near the name. The monitoring team was not able to determine if this was a different psychiatrist reviewing the plan for this individual now receiving a different medication regimen than was noted in the PSP addendum dated 5/9/11. The PBSP noted that the psychotropic medication (Depakote ER, Zyprexa) was prescribed for Schizoaffective Disorder, Bipolar Type. • PSPAs dated 8/12/11, 8/23/11, and 9/8/11 noted attendance by psychiatrist Dr. Gregory Creager. The team met 9/8/11 to discuss the weekly assessments completed by the psychologist and the psychiatrist. It was imperative for the different departments to communicate with one another for the reporting of this restrictive measure (i.e., emergency chemical restraint) to allow for appropriate assessment and intervention to take place by the PST. The use of emergency psychotropic medication is one additional set of data that should become part of the facility's QA program.	
J4	Commencing within six months of the Effective Date hereof and with	Documentation provided by MSSLC revealed that for the past six months there were a total of 28 instances whereby 22 individuals received pretreatment sedation for medical	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within 18 months, if pretreatment 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 pretreatment sedation. The pretreatment 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.	(26) or dental procedures (2) at MSSLC. Note, however, that this calculation did not include pretreatment sedation that was prescribed at an off-site dental clinic where many of the individuals received dental service. This number should be incorporated into the MSSLC data set. Of the 22 individuals listed that received pretreatment sedation, 20 were enrolled in the psychiatric clinic. The most common pretreatment sedation agent administered was Ativan. The monitoring team requested 10 examples of documentation of psychiatry consultation regarding pretreatment sedation for dental or medical clinic. No examples were provided. Of these 22 individuals, only one was scheduled for development of a desensitization plan with the rest being deemed "N/A." A list of all individuals with medical/dental desensitization plans and date of implementation were requested. There were no desensitization plans available for medical. For dental, the same five plans were provided to the monitoring team that were presented at the last onsite visit. These five plans were for Individual #500 (12/14/10), Individual #196, (9/16/10), Individual #481(9/20/10), Individual #369 (9/29/10), and Individual #456 (7/18/11). As identified by date, only one individual had a plan that was implemented since the last visit (7/18/11), but the plan was presented during the previous review (Individual #456). Medical staff also reported that there were no desensitization plans developed for the purpose of medical procedures. The medical director noted in the POI dated 9/8/11 that each PCP submitted a list of all the individuals in his or her care who had pretreatment sedation for the past 12 months. If desensitization plans were recommended, referral was sent to the psychology department. This list was also discussed at the physicians' weekly meeting with the facility psychiatrists. The medical director informed the monitoring team that consent was not obtained for pretreatment sedation. There was not a policy and procedure outlining the necessity of coordination between disciplines for pretreatment sedation, such as addressing consent, monitoring of the individual pre- and post-administration for status checks and detection of side effects, and documentation by the PST (i.e., psychiatry, pharmacy, medical services) within the PSP of strategies to minimize the need for the medication. Even so, the PSTs were beginning to address whether or not the individual required a desensitization plan in the PSP Addendum. For example, the PSPA dated 3/17/11 regarding Individual #165 noted that she was referred to the unit physician, "reference	

#	Provision	Assessment of Status	Compliance
		to the need for a desensitization plan for medical procedures…The team discussed this." Individual #165 had refused medical procedures, such as mammogram, pap test, etc. These were annual procedures and pretreatment sedation was given. The physician did not consider the individual to be a good candidate for a desensitization plan for the exams due to the infrequency of such screening. • The psychiatrist, however, was not present at this PSPA meeting even though Individual #165 was listed as receiving services in the psychiatric clinic. Further effort must be made with respect to the interdisciplinary review of pretreatment sedation and development of desensitization programs. They must be individualized according to the need and skill acquisition level of the individual, along with specific personalized reinforcers that would be desirable for the individual. In addition to working closely with psychology, the clinical pharmacist would be instrumental in providing the medication interactions and potential interactions of pretreatment sedation agents with concurrently prescribed medication. It would be beneficial for a process to be formalized in policy and procedure for this complex issue of ensuring that each individual receive an integrated assessment prior to being administered sedating medications that may have a negative clinical outcome particularly when utilized in combination with other medications prescribed for medical and/or psychiatric conditions. It would be helpful for MSSLC staff to review the way other facilities have addressed this provision and seek guidance from the statewide dental coordinator (i.e., implementation of a monthly multi-disciplinary review process including representation from dentistry, primary care, psychiatry, pharmacy, nursing, and psychology).	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	The census at MSSLC was 391 individuals. Of these, 259 individuals (66%) were prescribed psychotropic medication. Of these, 50 individuals were age 18 or younger, including two who were 12 years old. There were four full-time equivalent locum tenens psychiatrists, however, one had resigned and planned to depart in October 2011. There was not a designated lead psychiatrist. Therefore, the medical director filled the role of coordinating and supervising all of the psychiatrists. There were two designated psychiatric assistants that collected the data regarding psychiatry clinic. The two psychiatric assistants were hired to provide administrative support to the psychiatrists for scheduling evaluations, obtaining records and contact information, and other duties related to the coordination of psychiatric services. The psychiatric clinic schedule listed each psychiatrist as working 40 hours each week. The psychiatric staff rotated on call a week at a time. It was noted that each psychiatrist attended PST, PSPA, and other various meetings as needed, though actual data were not	Noncompliance

#	Provision	Assessment of Status	Compliance
		collected. The medical director informed the monitoring team that four FTE psychiatrists would allow the psychiatrist to provide care for the assigned 65 individuals to their caseload. The facility staff informed the monitoring team this would include enough time for the completion of the comprehensive assessments, attendance at meetings (e.g., polypharmacy committee, PST meetings, behavior therapy committee, physician's meetings, behavior support planning), other clinical activity, such as collaboration with primary care, neurology, other medical consultants, pharmacy, and psychology, provision of emergency psychiatric consultation, and more frequent monitoring for individuals whose medication dosages or regimen had recently been adjusted. The board certified forensic, adult, and child psychiatrist's contract dated 5/12/11 indicated services of phone consultation up to four hours/week for dates of coverage including 6/1/11 to 11/30/11 (see J1 above, including the recommendation for occasional onsite consultation). Overall, it appeared that MSSLC had done an adequate job in assessing the amount of psychiatric FTEs required. The facility provided a self-rating of noncompliance in the POI for this item because it had been difficult to recruit psychiatric applicants. Soon, there will be 3.0 FTE psychiatrists at MSSLC. The facility's history of inconsistent psychiatric staffing (e.g., last monitoring review, similarly, there were three out of four new locum tenens psychiatrists) and the rapid staffing turnover leads to disruption in the team building process. MSSLC has not yet demonstrated a consistent ability to employ or contract with a sufficient number of psychiatrists as required by this provision item.	
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.	MSSLC reported that 117 individuals had psychiatric evaluations performed according to Appendix B. Given that 259 individuals received treatment via psychiatry clinic, an additional 142 individuals still required a comprehensive psychiatric assessment. Thus 55% of the evaluations, as described in Appendix B, had not been completed. Given the remaining number of comprehensive psychiatric assessments this provision will remain in noncompliance. At the time of the last monitoring visit, 84 initial psychiatric evaluations had been completed for the individuals enrolled in psychiatric clinic. Thus, 33 comprehensive psychiatric assessments had been completed since then. The data indicated an average of five assessments were completed per month. Although progress was occurring, at this rate, it will take more than two years to complete all of them. A sample of 10 Appendix B style evaluations were reviewed. As also noted in J2, the	Noncompliance

#	Provision	Assessment of Status	Compliance
		required format was followed and reflected an improvement in documentation. An Appendix B evaluation for Individual #207 was provided to the monitoring team as an example. While the format was followed for the Appendix B outline and reflected an improvement in documentation, there were some sections that required additional information. • The evaluation did not have a date of the review on the first page. The last page had DR & DT date of 8/8/11. • The evaluation provided to the monitoring team did not have a psychiatrist's signature, therefore, the copy of the report may not have been a finalized document. • The psychiatrist adequately completed the assessment yet further information should be outlined in order to assist the PST in regards to diagnostic clarification and selection of an evidence-based treatment plan. • The psychiatrist should list specific medical information in regards to the individual's diagnosis of hypertension. Additionally for every psychiatric consult, in the medical history, all of the current medications, inclusive of dosage, should be listed. In the physical exam section, vital signs inclusive of orthostatic vitals (i.e., BP and pulse) and temperature must be included in the report for this individual receiving Clonidine (an anti-hypertensive medication) and psychotropic medication. The psychiatrist must guide the team in concert with the PCP for what is required of the team in monitoring of vitals and parameters (i.e., hold the medication for pulse less than…) because this individual received an antihypertensive agent in combination with psychotropic medications that can result in orthostatic hypotension and change in pulse, etc. The ECG result (current and/or prior reading, to cite the QT/QTc interval or other pertinent ECG findings), summary of cardiology consultation if obtained, etc. must be included in the report, and if not available specifically included in the recommendation to obtain, if clinically indicated. Medical information, such as weight with the weight range should be documented in the report and tracked for this overweight individual. Other medical data, such as labs should be included as well as results of urine drug screen, chemistry profile, lipids, thyroid function test, etc. The psychiatrist should list pertinent consultation results from neurologist (e.g., "Neurology increased Tegretol on such a date, therefore, Psychiatry will follow with Neurology regarding review of levels and will attempt to make one medication change at a time." Additional expectations would depend on the individual's medical condition. For example, if an individual had renal function impairment and the psychiatrist has traditionally used Lithium, then the psychiatrist would document the specialist's	

#	Provision	Assessment of Status	Compliance
		recommendation, results of chemistry profiles, and the psychiatrist's recommendations regarding reasons of choosing a different medication or continuing the same medication after weighing the benefits vs. risks. The case formulation should identify detailed reasons for the justification of the chosen diagnoses in an outline in line with the DSMIV-TR. The biopsychosocial approach and language similar to the DSM-IV-TR would guide the reader about why another or additional diagnosis was considered, such as an assigned rule out condition (i.e., Rule out Bipolar Disorder). This would be important in order to differentiate symptomatology (e.g., whether prior substance abuse potentially contributed to a presentation that resulted in the appointment of a Bipolar Disorder diagnosis). Treatment recommendations also need to outline the intention of each medication and to review potential drug-drug interactions and risk benefit analysis of the selection of the particular regimen. For example, for what reason were two agents, both with anticholinergic properties selected, as opposed to one? Did Sertraline (an antidepressant) possibly contribute to some of the features and was this the reason for a rule out Bipolar Disorder diagnosis? For Individual #207, the recommendations noted that Geodon and Sertraline were both being given for "mood disorder," yet the recommendation noted possibly adding another "mood stabilizer." The psychiatrist must guide the PST in a detailed fashion about what to monitor in order to determine medication efficacy in an evidence-based manner to avoid the use of polypharmacy unnecessarily.	
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	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 facility had 27 new admissions for the previous six months and 100% of these individuals were administered a Reiss screen. • Additionally, for the last six months, the POI noted that: o all new admissions had an Initial Psychiatric Evaluation (IPE) and o all individuals referred by the psychology department with a positive Reiss screening had a comprehensive psychiatric evaluation within two weeks. The monitoring team's review, however, found inconsistencies in the data provided by MSSLC regarding the date of completion of the comprehensive psychiatric evaluation as well the as the provision of psychiatric services based upon the results of the screen, as illustrated in the following examples. • The monitoring team noted a confusing entry for Individual #559. This individual's Reiss was administered three months after admission. Further, it	Noncompliance

#	Provision	Assessment of Status	Compliance
	psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	was cited that the results of the Reiss suggested that she "does not currently appear to have a need for psychiatric services. This is consistent with the current psychiatric diagnoses which include Conduct Disorder and Bipolar Disorder." If the individual had symptoms to constitute the diagnosis of Bipolar Disorder, then psychiatric services would be indicated. The Reiss screen is not deemed to be a sufficient measure to replace a comprehensive psychiatric evaluation. Further, Individual #559 was not listed in the psychiatric database and there was not a comprehensive psychiatric evaluation listed for this individual who had a diagnosis of Bipolar Disorder. • Another entry in the Reiss document request noted that Individual #42 was received a Reiss more than a month after admission. The results of the Reiss suggested that he "does currently appear to have a need for psychiatric services based on the results of the Reiss…results of this scale do not appear to be fully consistent with the current psychiatric diagnoses of Bipolar Disorder, Intermittent Explosive Disorder and Mild Mental Retardation." This individual was not enrolled in psychiatry clinic and there was not a comprehensive psychiatric evaluation listed as being obtained, but it seemed to the monitoring team that there should have been an evaluation conducted. • Individual #136 was admitted and received a Reiss screen within 30 days. The results of the Reiss suggested that he "does currently appear to have a need for psychiatric services…consistent with the current psychiatric diagnosis… Sexual Abuse of a Child (victim)." This individual, however, was not enrolled in psychiatry clinic and there had not had a comprehensive psychiatric evaluation, according to the list submitted by the facility. This provision requires 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. Further, some individuals were referred by psychology for a Reiss Screen, however, there was no indication as to what change in status had occurred that resulted in this referral.	
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	A review of the psychiatric and psychological documentation indicated inadequacies in combined case formulations. First, there was no policy or procedure to guide this process. Second, this type of collaboration should be evident in psychiatry clinic, the psychiatric treatment plan, psychiatric assessments, the PSP process, the PBSP process, and, hopefully, within other interventions and disciplines (e.g., speech and language, OTPT, medical). Interviews conducted during this monitoring review revealed that combined case	Noncompliance

#	Provision	Assessment of Status	Compliance
	combined assessment and case formulation.	assessments and formulations had been inconsistently occurring since the last review. There were, however, the beginnings of integration between psychiatry and psychology, specifically the reported attempts by psychiatry to attend some PSP meetings, and there were also opportunities for interaction during psychiatry clinic with the psychologist and other disciplines. The monitoring team observed four separate psychiatric clinics held with four different PSTs. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, PST members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines, yet psychology did not consistently provide data of the essential target symptoms that were deemed necessary for monitoring of the current psychiatric diagnosis. Further, depending on what document was reviewed, there were varied diagnoses. It will be difficult for psychology and psychiatry to establish a working relationship due to the frequency of staff turnover. For example, turnover resulted in different psychiatrists being responsible for the psychiatric care of an individual, and as a result, diagnostics and treatment regimens changed. When this occurs without the integration and support of the PST, and without a history of combined case formulation, psychiatry and psychology will not be (and were not) aligned. As a result, for example, they did not identify similar content and there were differences in the identification of the target symptoms (psychiatry) and target behaviors (psychology) that would be monitored. These differences impacted the overall review of efficacy of pharmacological treatment and also altered the determination of specific behavioral and other interventions specific to the individual's needs. Medication decisions made during clinic observations conducted during this onsite review were based on lengthy (minimum 30 minute) observations/interactions with the individuals as well as the review of information provided during the time of the clinic. In the four clinic observations, the psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress with them, and discussed the plan, if any, for changes to the medication regimen. This was good to see. Psychology and psychiatry need to formulate diagnoses and plans for treatment as a team. There was minimal discussion during the psychiatric clinics regarding objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted	

#	Provision	Assessment of Status	Compliance
		interventions. To reiterate, one area of integration that required attention was regarding the use of data. Both psychiatry and psychology staff voiced concern regarding the accuracy of the choice of clinical indicators for the individual. It was also notable that graphs of data presented to the physician should include other potential antecedents for changes in target behavior frequency, such as changes in the individual's life (e.g., change in preferred staff, death of a family member), social and situational factors (e.g., move to a new home, begin a new job), or health-related variables (e.g., illnesses, allergies).	
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 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.	Per interviews of both psychiatry and psychology staff, psychiatry did not routinely attend meetings regarding behavioral support planning for individuals assigned to their own caseload, and was not consistently involved in the development of the plans. Therefore, this provision item was rated as being in noncompliance. Psychiatry, however, verbalized a willingness to become more involved, and reported that the present arrangement of spending hours in the Behavior Therapy Committee (BTC) was not the appropriate place to determine the least intrusive and most positive interventions for the individual's care (i.e., another method to meet this provision item will have to be determined). The psychiatrists were not familiar with most of the individuals being reviewed in the BTC regarding treatment of their behavioral or psychiatric condition because the individual's plan was not necessarily assigned to that particular psychiatrist's caseload. To meet the requirements of this provision item, there needs to be evidence that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item, and that the required elements are included in the document. Documents for individuals receiving newly prescribed medications and their PBSPs were reviewed. The PBSP for numerous individuals included a physician and/or psychiatrist signature (e.g., Individual #80, 4/19/11). Interviews with staff revealed that psychiatrists often signed the PBSP even though they were not active participants in the development of the plan. In conducting this review, a number of the examples were from the previous monitoring review and, in some cases, the monitoring team was unable to read the physician's signature and was not able to determine if it was a psychiatrist who was the actual participant. It would be beneficial for staff to print and sign their name and also specify whether he or she represented psychiatry. There was a pattern of different psychiatrists signing the same individual's plans (i.e., addendums held within a short time frame of one another). This indicated the lack of a core group team understanding of the individual's psychiatric and behavioral presentation over time.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The psychiatrist that participated in the BTC was aware that the behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports, were not necessarily chosen due to the identified psychiatric diagnosis. The psychiatrist attempted to give feedback to the psychology staff during the BTC, but the meeting was already burdensome due to numerous plans requiring approval and, further, was not the appropriate time to make any treatment revisions. Further, the psychology staff found it difficult to process the psychiatrist's feedback in this setting. The monitoring team provided feedback to psychiatry that their participation must occur before a proposed PBSP for individuals receiving psychiatric care is implemented. The monitoring team discouraged the practice of psychiatry reviewing the PBSP for the first time in the BTC, especially when it was a PBSP of an unfamiliar individual under the care of another psychiatrist. During the psychiatric clinics observed, the psychiatric staff and PST engaged in discussion of non-pharmacological interventions provided to the individuals (e.g., individual that lost a family member was receiving pastoral counseling during the grief stage and responded positively to this non-pharmacological measure). The monitoring team acknowledged the PST's efforts in thoroughly reviewing this type of pertinent information and non-pharmacological approach. PSP and PSPAs were typed which made it easier to determine if the psychiatrist was "in attendance for deliberation." For example, Dr. Swicegood's signature was legible and noted her attendance for Individual #92, PSPA dated 7/21/11. The issue was a new diagnosis of "hyponatremia." The team discussed the continued need to provide one-to-one staff to minimize unauthorized departures and property damage, and to monitor for psychiatric symptoms 24 hours a day. This individual had had a medication change (i.e., Ambien was discontinued and Abilify was increased). The monitoring team encouraged the medical director, psychiatrists, and psychiatric assistants to develop a system to record participation of the psychiatrists in the various meetings. The psychiatric database listed the dates of the individual's PSP and PBSP and the psychiatrist assigned to the individual's care, but did not specify if the psychiatrist was present or not at these meetings. To adequately complete self-assessments for this provision item, MSSLC should begin to collect data, such as number and percentage of meetings attended by the psychiatric staff (e.g., PSPs, PSPAs, PBSPs). As stated in other sections of this report on provision J, psychiatry and psychology must learn how they can assist each other toward the common goal of appropriate treatment interventions, both pharmacological and non-pharmacological.	

#	Provision	Assessment of Status	Compliance
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	A review of DADS policy and procedure entitled "Psychiatry Services," dated 8/30/11, noted that state centers "must ensure that individuals are evaluated and diagnosed by a psychiatrist prior to administration of psychotropic medications…The psychiatrist, in conjunction with the PST and pharmacist, must conduct quarterly reviews of the assessment of the risk versus benefit of continued psychotropic medication therapy as well as the appropriateness of drug selection, effectiveness, dosage, and presence or absence of side effects." The MSSLC facility-specific policy, "Psychiatry Clinics Policies and Procedures Manual" was dated 8/24/11, prior to the implementation of the updated DADS policy and procedure. The responsibilities of the psychiatrist included leading the "discussion and case formulation, determine the appropriate target symptoms and diagnosis, weigh the risk/benefits of medications and decide whether the pharmacologic therapy is indicated…order the type of monitoring needed to determine efficacy and side effects of the medication." Per staff interview and record review, there had been minimal change in practice with regard to this provision in the intervening period since the previous monitoring review. A current review of the records of 20 individuals who were prescribed various psychotropic medications did not reveal documentation by the psychiatric physician of an individualized specific risk/benefit analysis with regard to treatment with medication as required by this provision item. There were, however, comments regarding the risk/benefit analysis for treatment with psychotropic medications and restrictive programming included in the positive behavioral support plans. These were authored by psychology staff and, therefore, did not satisfy the requirements of this provision item or meet generally accepted professional standards of care. Psychiatry staff reported that documentation of this information in the PBSP by non-prescribing professionals was not appropriate. There was a need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially more dangerous, than the medications. As discussed with facility staff during the monitoring review, the risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician, however, the success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data	Noncompliance

#	Provision	Assessment of Status	Compliance
		regarding the individual's target symptom monitoring is provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician reviews said data, and that this information is utilized in the risk/benefit analysis. The input of the various disciplines must be documented in order for the facility to meet the requirements of this provision item. The development of the risk/benefit analysis could be undertaken during psychiatry clinic. During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed some of the laboratory findings with the PST, but did not thoroughly outline findings in the documentation in the records reviewed in the form of a risk/benefit analysis. The structure of the quarterly psychiatry form utilized at MSSLC may hinder this process because the form had check boxes and did not allow adequate space for documentation. The team should consider reviewing this type of information together via a projector/screen and typing the information during the clinic process. The psychiatric assistants were sometimes present in the clinic, but were seated off to the side by themselves, had access to a computer, and were not engaged in the content being exchanged during the clinic. The QMRP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. Recommendations include accomplishing this goal together with the PST by holding lengthier clinics (i.e., 45-60 minutes/individual consult), access to equipment, and typing information received in the clinic setting. Of course, for the initial entry in the documentation, some prep time would be necessary to set up the shell of the document. The monitoring team is available to facilitate further discussion in regards to this recommendation, if requested. The documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the PST, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). HRC documentation received for the 10 newly prescribed medications noted examples that reflected "HRC Review Of BSP" without adequately identifying a "risk vs. risk analysis." The monitoring team attended the BTC committee and stressed the importance of the psychiatrist and the PST reviewing the content of this provision and, further, that is was not adequate to have medications outlined with generic statements along with the	

#	Provision	Assessment of Status	Compliance
		restrictive programming plan that was pervasive throughout the documents reviewed. For example, the PST review dated 11/1/10 with a HRC review date of 5/31/11. This individual was prescribed "Strattera, Xanax ER, Paxil, and Zyprexa." Risk vs. Risk Analysis: "Risk of losing time spent in preferred activities while in restraint or local time out is less than the risk of harm to self or others." The monitoring team would also like to request that new information be provided for these reviews as opposed to outdated/repeated information from the previous visit.	
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 POI self-rated the facility in substantial compliance for this item. The monitoring team, however, did not agree and rated noncompliance as described below. The medical director described the polypharmacy committee and said that it was attended by all the psychiatrists, PCPs, when needed, and the psychology director or her representative. The medical director was under the impression that just the formation of the review system was sufficient to achieve substantial compliance. The monitoring team explained to her and to the polypharmacy committee that the intention of the facility-level review was to ensure that the uses of psychotropic medications were clinically justified, and that medications that were not clinically justified were eliminated. The monitoring team attended the polypharmacy meeting during the onsite visit. Since last visit the cases of polypharmacy continued to increase as illustrated by a graph displaying total cases of polypharmacy by month and number of medications (e.g., specifically, 68 cases in March 2011 to 86 cases in July 2011). For future onsite reviews, it would be helpful for the facility polypharmacy review to take place at the beginning of the week so that the monitoring team can provide feedback throughout the remainder of the week. During this review, the monitoring team gave feedback to the polypharmacy committee regarding the case discussions presented by the psychiatrists. • The clinical indicators outlined for the review were not reflective of evidence-based practice for evaluating efficacy of the selected medication regimen. For example, Individual #420 had diagnoses of schizoaffective disorder and nicotine dependence. The target symptoms identified for the review at the polypharmacy meeting included high levels of interpersonal violence and use of high tobacco content. Individual #420 was prescribed four psychotropic medications inclusive of intra-class and inter-class polypharmacy (e.g., Abilify, Haldol, Lithium SR, Depakene). • The target symptoms did not address whether the medication was prescribed for actual psychiatric symptoms (i.e., hallucinations and/or affective disturbance). Thus, the team could not accurately detect if the medications were	Noncompliance

#	Provision	Assessment of Status	Compliance
		effective for the identified psychiatric illness. In other words, it was not clear if the psychiatric illnesses of psychosis and affective instability were the reason the individual had problems with interpersonal violence, because the data were not designed to capture such information. The monitoring team recommended that the psychiatrists implement a peer review system regarding polypharmacy in order to provide feedback to one another and to address this serious aspect of delivery of psychiatric services, particularly in MSSLC's environment of frequent staff changes in psychiatry. The review of the polypharmacy provided by the committee appeared to not be an active exercise to minimize unnecessary medications, but more of an imposed requirement placed upon the committee. This was not overly surprising given that the committee was assigned the burdensome task of reading 25 typed pages of information, including the individual's name, psycho-actives, indications, target symptoms, psychiatric diagnoses, and discussion categories, without the apparent leadership of how to approach such information. The medical director informed the monitoring team that it would be beneficial for the psychiatrists to have a lead psychiatrist designated to facilitate the implementation of Section J since her specialty was not in the field of psychiatry. Documentation of minutes from this monthly meeting indicated that, overall, the total number of individuals residing at the facility prescribed polypharmacy had increased from 54 in August 2010 to 86 in July 2011. Three individuals listed in this summary (July 2011) received as many as six or more psychotropic agents with seven individuals prescribed five medications for psychiatric purposes. Seventy-two of 86 individuals captured in the polypharmacy category received at least three or more psychotropic medications. Upon further inquiry, the monitoring team learned that the medications for seizure disorder or other medical conditions were not listed in this count. Although it was appropriate that other medications were not specifically included in the count, the polypharmacy committee must be aware of all medications that the individual was prescribed in order to further determine the next plan of action. Individuals with a psychiatric illness, particularly those also with a neurological condition, such as a seizure disorder, must be analyzed in view of their overall medical condition in regards to potential drug-drug interactions. Additionally, case review and integration of data for individuals prescribed pretreatment sedation and polypharmacy was imperative in order to avoid further drug-drug interactions for those already prescribed numerous medications. Thus, the importance of ongoing monitoring for side effects, adverse drug reactions, and quarterly drug regimen reviews remained very important (see Section N).	

#	Provision	Assessment of Status	Compliance
		As was discussed during the onsite review, in some cases, prescribed treatment with multiple medications may be absolutely appropriate and indicated for many individuals. This should be the exception and not the standard approach of the facility. The prescriber must, however, justify the clinical hypothesis guiding said treatment. Additional information would be necessary in order to adequately justify the use of polypharmacy. Curiously, the psychiatry staff was not able to provide the monitoring team of even one example that would warrant the consideration of medication reduction. The facility will need to address this philosophy and establish reasons for the hesitancy exhibited to minimize polypharmacy and determine what may be contributory.	
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.	For the last two quarters, the QDRR tracking of the MOSES and DISCUS compliance were approximately 90% completed in a timely manner. For the second quarter, as captured in the 2011 QDRRs, however, several MOSES/DISCUS screenings were "not done on time;" these cases were referred to the nursing department. Once side effects were detected, reporting was to occur and response taken based on the individual's status. It was observed during the psychiatry clinic, that when an individual experienced an adverse reaction and/or side effect of a psychotropic medication, the PST did not understand the importance of actually reporting, such as by filling out an ADR. One PST, for example, discovered a situation that should have resulted in the reporting of an ADR, however, they admitted that they were not certain of how to proceed. The monitoring team brought this topic to the attention of members of the P& T committee during the discussion of ADRs. The PCPs, psychiatrists, pharmacy staff, and nursing staff discussed this issue at length and the impact from a medical and legal perspective when entered incorrectly in the medical record. Nursing staff had inservice training regarding MOSES and DISCUS examinations. Documentation revealed that numerous trainings for MOSES/DISCUS among other topics were covered in the "Summary of Program Content" training roster that occurred in 2011 (8/11-seven nursing staff attended; 7/11-two attended; 6/11 three nursing staff attended; 3/11 four nursing staff attended). Four individuals were noted to have the diagnosis of tardive dyskinesia (TD). Upon review of this list, the psychiatrist noted that one of the individuals listed (Individual #562), did not have TD (according to the psychiatrist note in the 6/22/11 MOSES). Upon review of the scores provided to the monitoring team, as many as 13 individuals had elevated DISCUS scores that should have prompted further discussion and consideration of a diagnosis of TD. Some of the scores were as high as 20 for the DISCUS measure. The DISCUS only has 15 items to review with four being the most severe scoring.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The report of only four individuals having a diagnosis of TD resulted in the monitoring team's concern about inadequate training and lack of appropriate interpretation of the results of the assessment tool. Last review, there were 18 individuals diagnosed with TD. Therefore, the number reported at the time of this visit did not appear accurate. Although medications, such as antipsychotics and Metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). Medication reduction or absence of the antipsychotic or Metoclopramide that occurred during a taper or discontinuation may result in increased involuntary movements, 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. Given the need for the demonstration of the consistent identification of individuals (i.e., obtaining and applying pertinent history discovered about previous exposure to medications that cause TD) experiencing side effects and the need for the utilization of this information in clinical decision-making, this provision will be rated as being in noncompliance.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral 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	The psychiatric assistants reviewed the Presentation Book Evidence Section J with the monitoring team; it included a review of the facility's policy and procedure manual regarding the provision of psychiatric care. Per record reviews conducted by the monitoring team there were no specific treatment plans for psychotropic medication that contained the components required by this provision item. The POI noted that psychiatrists attended PSPAs to discuss treatment options for the individual and treatment plans were being documented in the IPN, however, the monitoring team did not find any documents identified as psychiatric treatment plans. If done correctly, however, the psychiatrist's initial and follow-up evaluations can address the components of a psychiatric treatment plan in the assessment and recommendation sections. A review of documentation provided inclusive of the integrated progress notes inconsistently noted the rationale for the psychiatrist choosing the medication (i.e., the current diagnosis or the behavioral/pharmacological treatment hypothesis). Other required elements (the expected timeline 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) were not consistently outlined in the records. Individuals were seen in psychiatry clinic quarterly, or more frequently, as needed.	Noncompliance

#	Provision	Assessment of Status	Compliance
	necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	During the monitoring review, four psychiatry clinics were observed. In all instances, the individual was present for the clinic due to the psychiatric assistants' collaboration and communication with the individual's PST. All treatment team disciplines were represented during each clinical encounter. The team did not rush clinic, often spending more than 40 minutes with the individual and discussing the individual's treatment. There were some improvements noted regarding exchange of pertinent information during some of the psychiatric clinics, however, the data predominantly focused on behavioral presentation (i.e., self-injurious behavior or aggression towards others). This information, although relevant, was insufficient if the goal was to implement an evidence-based approach in evaluating medication efficacy associated with a psychiatric disorder. For Individual #386, the psychiatrist had previously recommended the initiation of an antidepressant. • Unfortunately, consent was not obtained for this juvenile, and this delayed the treatment intervention. The meeting observed by the monitoring team was when the psychiatrist was first told of this by the PST (i.e., lack of consent). This provision item specifically requires that the PST, including the psychiatrist, was to establish the expected timeline for the therapeutic effects of the medication to occur. This lack of team integration was an example of how individuals suffer from symptoms of psychiatric illness if the components of this provision item are not addressed, beginning with ensuring the implementation of the treatment plan. • The "Tracking Data from Psychology" section in the QPMR dated 9/20/11 noted a decrease "in behavior issues as per psychologist…feels depressed." Individual #386 had experienced the loss of a family member. The diagnosis was listed as Bipolar D/O-mixed. The psychiatrist appropriately listed the medication indications, however, was unaware (until the meeting observed by the monitoring team) that the prescribed treatment was never initiated. Weight was noted to increase from 159 pounds in July 2011 to 167 pounds in September 2011. The established weight range was not noted in this summary, therefore, it was difficult to interpret if this was of concern. Labs, such as FBS and lipids, were reviewed. The HDL was noted to be low while the LDL was elevated for this juvenile who was receiving olanzapine (Zyprexa), an agent that is known to cause weight gain and dyslipidemia. • The QPMR form did not allow adequate writing space for the psychiatrist to complete documentation, which was a similar problem for other psychiatrist's clinic documentation. The psychiatrist did not refer the reader to the IPN for continuation of the QPMR documentation, however, the IPN dated 9/20/11 had	

#	Provision	Assessment of Status	Compliance
		an entry "Psych QPMR cont'd" inclusive of a lengthy explanation of what occurred since last visit, explaining how other services, such as counseling, might have resulted in the individual improving, and outlining a portion of the mental status exam. The PST was concerned for the youth and had an active discussion about his situation. The plan included "get consent for antidepressant…, CBC lipids, FBS. Continue Zyprexa 20 mg hs." • The monitoring team encouraged the psychiatrist to access the child/forensic consultant available to the facility due to the consultant forensic and legal experience. Also, the child/forensic psychiatrist would be helpful to facilitate implementation of appropriate informed consent process to expedite the delivery of psychiatric services. It was apparent that no one was delegated to monitor the sequence of events that should have occurred for the care of this youth, resulting in him experiencing psychiatric symptomatology that was not addressed pharmacologically as was recommended per the psychiatrist. In most cases, the psychiatrist displayed competency in verbalizing the rationale for the prescription of medication, for the biological reason(s) that an individual could be experiencing difficulties, and for how a specific medication could address said difficulties. This information, however, must be spelled out in the psychiatric documentation. During the review, it was discussed with members of both the psychiatry and psychology staff that improved integration of their departments will be necessary in order to meet the requirements of provision J. A review of documentation did not reveal consistent collaborative case conceptualizations or diagnostic formulations. Currently, both departments were determining how they could assist each other and what information and services they can obtain from the each other. The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to psychopharmacological interventions, and the monitoring of specific clinical indicators to determine the efficacy of the prescribed medication. Dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response via a clinical encounter with the individual and a review of appropriate target data (both pre and post the medication adjustment), the physician can determine the benefit, or lack thereof, of each medication adjustment.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal	In the DADS policy, Psychiatry Services #007.2, state center responsibility #15 said that, "State Centers must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures." At MSSLC, the psychology department obtained consents for psychotropic medications,	Noncompliance

#	Provision	Assessment of Status	Compliance
	authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	not the medical department. Per the director of psychology, the psychology staff had been responsible for the coordination of consent for psychotropic medication due to difficulty with the hiring and retention of psychiatry staff (see J1 and J5 above). Both departments wanted the "Client Management Policy 19-Positive Behavior support" to be updated to reflect psychiatry's responsibility for obtaining consent for psychotropic medication. The monitoring team is in agreement with this. As noted in the POI, a meeting was held between the psychiatry department and psychology department to discuss the issue of consent. The monitoring team met with Ms. Benson, the interim facility director, to discuss the topic of consent for psychotropic medication and the need for the facility to handle this medical consent consistent with other medical policy and procedures for obtaining consent. Further, of note, upon interview with the medical director, consent was not obtained for pretreatment sedation. Based on some of the discussions with the monitoring team during the week of the onsite review, the process for informed consent was beginning to transition from the psychology department to the medical department. For example, Dr. Creager presented a "Consent Form For Medication" that he completed, dated 9/20/11, to the monitoring team. Dr. Creager's consent form dated 9/20/11 for Individual #457 outlined the majority of appropriate informed consent practices, including the type and dosage range of the medication. The chosen antipsychotic listed the reason for the medication as "treatment of psychotic disorder" to "minimize thought disorganization…" The risks summarized were comprehensive and relevant. The example of Individual #457's consent form completed by the psychiatrist was a vast improvement compared to prior consents reviewed during the last monitoring visit. The content filled out by Dr. Creager was in line with generally accepted professional standards of care, but it was not totally complete due to the actual consent form at MSSLC not including all of the necessary components of an informed consent procedure for medication. For example, alternatives and associated risks (e.g., therapies/programs available if the individual refuses treatment with medication and that have been considered, tried, and/or rejected), and risk of no treatment need to be included. An adequate risk versus benefit analysis must be documented as opposed to just citing the risks in the section titled, benefits and risks. There should also be an area where the individual and/or LAR can print their names. This would allow identification of the individual and/or the relationship of the designee for the individual. The current form had a "Superintendent Designee's signature" line and it was difficult to determine who actually signed the consent form.	

#	Provision	Assessment of Status	Compliance
		The consent documents did not include the name of the "person giving explanation." Further, staff must review the estimated duration of the validity of consent for the medication, consistent with state consent guidelines (i.e., current consent was as lengthy as 15 months in duration) and whether this should be less for specific measures (i.e., pretreatment sedation medication). A consent form, once completed, was then presented to the Human Rights committee for review before a non-emergency medication was given. In an effort to address the inadequacies in informed consent practices, it was recommended that the facility consult with the state office, who, in turn, may want to consider a statewide policy and procedure outlining appropriate informed consent practices that comply with Texas state law and generally accepted medical practice. To summarize, current facility practice was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual (or their guardian) 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 be documented in the individual's record.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Per DADS policy entitled, Psychiatry Services, #007.2 dated 8/30/11, " the neurologist and psychiatrist must coordinate the use of medications, through the PST process, when the medications are prescribed to treat both seizures and a mental health disorder." A review of documents, including facility based policy and procedure regarding psychiatric treatment at the facility, did not reveal additional policy and procedure regarding this issue. Per interviews with the facility medical director, there had been efforts to coordinate care with neurology. As noted in the POI, there had been monthly scan calls with the Scott & White Hospital neurology department to discuss all intractable seizures. In regard to a record request for the schedule of the consulting neurologist, the monitoring team received the following: "All Neurology consultations are sent to Scott & White Hospital on a referral basis and the Neurology Department schedules all appointments based on the Neurologist's schedule. We do not have a copy of the Neurologist's schedule." In other words, there was no reference that a neuropsychiatric clinic was ever scheduled.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A list of individuals participating in the psychiatry clinic who had a diagnosis of seizure disorder included 53 individuals. The records for Individual #567 were reviewed because this individual was enrolled in psychiatry clinic and had a seizure disorder. Neuropsychiatric consultation requires the participation of a neurologist and a psychiatrist. For example, neurology provided consultation 8/31/11 via telephone to the PCP, but psychiatry was not included in the correspondence for this individual who was receiving polypharmacy. Individual #567 had breakthrough seizures despite treatment with Divalproex ER. He had been evaluated per neurologist, Dr. Kirmani 8/2/11 with recommendations to initiate Lyrica. The PCP at MSSLC "feels that Lyrica will lead to increased somnolence and weight gain…already experienced these side effects with his other medications. The decision was made today by the team to change to Topamax," but the team did not include the input from the psychiatrist for this individual that received medications to treat both seizures and a mental health disorder. This individual's presenting symptoms of breakthrough seizures, side effects with other medications, and psychiatric disorder represented the necessity of the neurologist and psychiatrist for the coordination of the use of medications, through the PST, when they were prescribed to treat both seizures and a mental health disorder. • Initial psychiatric evaluation dated 8/13/11 acknowledged that this individual's case was new to the psychiatrist. Target behaviors included aggression, self-injurious behavior, suicide threats and actions, and ingesting inedible objects. There was no mention by the psychiatrist of the need to monitor a change in the mental status associated with seizure activity for this individual with intractable epilepsy. The psychiatrist outlined a thorough description of potential interactions of the polypharmacy regimen and the fact that Individual #567 received "two antipsychotics without clear justification." The psychiatrist noted that following a taper of the "Doxepin, based on the fact that Ativan (benzodiazepine) has a history of causing aggression, I would likely either stop or taper" the Clonazepam (benzodiazepine). The recommendation to discontinue a medication, such as a benzodiazepine (depending on dosage, etc.) may result in occurrence of increased frequency of seizure activity because benzodiazepines can also target seizures. Thus, the psychiatrist should obtain consultation with the PST, including the neurologist, prior to discontinuation of an anti-epileptic agent, particularly for individuals with breakthrough seizures. Similarly for the neurologist choosing an agent such as Topamax without the PST including the psychiatrist, such medication may not be best due to the individual's psychiatric presentation. Regardless, the change in medication whether AED from the neurologist or adjustment of psychotropic from the psychiatrist should occur with the plan of one medication change at a time and	

#	Provision	Assessment of Status	Compliance
		monitoring of seizures, side effects, drug-drug interactions, and mental status changes. As the psychiatrist nicely outlined, when one medication is changed it can actually affect the level of the other medication (i.e., increase or decrease). These type of drug interactions require thorough review particularly for individuals with intractable epilepsy and how this may impact the seizure disorder and mental status presentation. It would be helpful for the facility to learn how other SSLCs are addressing this provision item to implement appropriate clinical care (e.g., monthly neuropsychiatric clinic).	

Recommendations:

1. Staff to include a child psychiatrist preferably with specialty in forensic psychiatry to manage the care and/or routinely review the identified individual's care with the general psychiatric staff (i.e., youth under the age of 14; youth that were prescribed polypharmacy or had complex psychiatric conditions; youth involved in the judicial system). Onsite consultation and/or telemedicine contact is recommended as opposed to all consultations being performed via phone only (J1).

2. The assignment of cases should depend on the psychiatrist's experience. Encourage psychiatrists to update their curriculum vitae to include present job experience at MSSLC (start date), 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 he or she has ever been deemed an expert for court testimony in the State of Texas, specifically citing the District, reason, and date of such testimony (J1).

3. Consider appointing a mentor for the facility psychiatrists, specifically a psychiatrist at another facility who was familiar with the requirements and challenges of working in the DADS system. This could include the development of a peer review process across several facilities (J2).

4. Designate a lead psychiatrist to develop a system level of integration between the psychiatric practitioners and psychology staff. The lead psychiatrist should work closely with the medical director developing and implementing a system of psychiatric care and services with other disciplines as outlined in the Settlement Agreement (J2, J3, J4, J8, J9).

5. Develop a recruitment/retention plan for psychiatry. The facility should consider the development of a "pearls of wisdom" book. This would be an information book for psychiatry that outlines information that is specific to the practice of psychiatry within the facility, and ease the transition for both the physician and staff (J3, J9, J12, J13).

6. Integrate the prescribing psychiatrist into the overall treatment program at the facility as follows (J3, J8, J9, J13):
    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 clinical indicators to be monitored;
g. Psychiatry should be consulted regarding non- pharmacological interventions.

7. Individualize the desensitization plans for dental and medical clinic. Implement cross-discipline consultation regarding pretreatment sedation options (J4).

8. Ensure that the clinical indicators/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication were appropriate (J2, J8, J13).
    a. If DSM-IV-TR diagnosis was met, utilize medication that has validated efficacy as supported by evidence-based practice, and that was the appropriate course of intervention in concert with behavioral intervention.
    b. 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.
    c. 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.

9. Any change in diagnostics should summarize the symptoms and criteria met according to DSM-IV-TR to justify the diagnosis (J2, J8, J13).

10. 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) (J8).

11. 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 (J2, J10, J12, J13):
    a. PST to rule out medical etiology of presenting symptomatology (if clinically indicated) 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 provision of 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 PST 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.

12. Complete the comprehensive psychiatric evaluations following the requirements of the Settlement Agreement Appendix B (J6).

13. Determine the mechanism for referral for psychiatric evaluation following a positive Reiss Screen or following a change in psychiatric, behavioral, and/or medical status (J7).

14. In an effort to address the deficit regarding informed consent practices, it is 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 (J14).

15. Formalization of the PSP process to include review of the risk/benefit ratios for the prescription of psychotropic medications that are authored by psychiatry. Individualize the risk versus benefit for each psychotropic medication prescribed. For example, if an individual has diabetes mellitus, and was prescribed a medication that exacerbated Diabetes (e.g., Zyprexa, an atypical antipsychotic), then outline justification (J10).

16. 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 (J11).

17. 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 (J11).

18. 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. 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. It would be helpful for the facility to learn how other centers are addressing necessary interaction between psychiatry and neurology to implement appropriate clinical care (e.g., monthly neuropsychiatric clinic) (J15).

19. Improve data collection regarding the use of emergency psychotropic medications. The use of emergency psychotropic medication is one additional set of data that should become part of the facility's QA program (J3).

20. All lists and data submitted to the monitoring team to include a date on the document. Numerous documents received by the monitoring team were not dated and, therefore, it was difficult for the monitoring team to interpret percentages of completion of tasks within the time frame since the last monitoring visit (J3, J11).

21. To adequately complete self-assessments, collect data such as number and percentage of meetings attended by the psychiatric staff (i.e., PSPs, PSPAs, PBSPs, etc.). The psychiatric database lists the dates of the individual's PSP and BSP and the psychiatrist assigned to the individual's care but did not specify if the psychiatrist was present or not at the meetings (J3, J9)

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 Functional Assessments for: • Individual #398 (7/3/11), Individual #483 (3/20/11), Individual #466 (3/28/11), Individual #392 (6/20/11), Individual #104 (7/10/11), Individual #157 (7/20/11), Individual #113 (8/3/11), Individual #222 (8/18/11), Individual #183 (9/12/11) o Positive Behavior Support Plans (PBSPs) for: • Individual #48 (8/19/11), Individual #385 (9/19/11), Individual #197 (9/12//11), Individual #508 (8/16/11), Individual #519 (9/14/11), Individual #353 (8/8/11), Individual #104 (7/12/11), Individual #398 (7/9/11), Individual #591 (5/19/11), Individual #157 (7/24/11), Individual #483 (4/12/11), Individual #225 (9/12/11), Individual #491 (8/11/11), Individual #451 (5/24/11), Individual #153 (8/2/11) o Six months of notes on PBSPs progress for: • Individual #591, Individual #398, Individual #157, Individual #113, Individual #104 o Full Psychological Assessments for: • Individual #366, Individual #324, Individual #554, Individual #537, Individual #198, Individual #48, Individual #211, Individual #207, Individual #362, Individual #305, Individual #33, Individual #424 o Annual Psychological updates for: • Individual #401 (2/1/11), Individual #550 (7/18/11), Individual #359 (8/17/11), Individual #373 (8/17/11), Individual #144 (8/17/11), Individual #583 (3/14/11), Individual #451 (1/11/11), Individual #177 (8/17/11), Individual #556 (8/17/11) o Data Project, September 2011 o List of individuals who are receiving counseling/psychotherapy, undated o Stars activity plan for: • Individual #466, Individual #233, Individual #250, Individual #125, Individual #347, Individual #325, Individual #421, Individual #144, Individual #556, Individual #242, Individual #183, Individual #126 o Internal Peer Review minutes for 5/4/11, 5/11/11, 5/25/11, 6/1/11, 6/8/11, 6/15/11, 6/22/11, 7/6/11, 7/13/11, 7/20/11, 8/3/11, o External Peer Review minutes for 3/17/11, 4/26/11, 5/20/11, 6/28/11, 7/28/11 o List of psychology department staff and status of enrollment in BCBA coursework, undated o List of individuals with a Positive Behavior Support Plan (PBSP), undated o List of individuals most recent psychological assessments, undated o List of all individuals for whom a functional assessment has been completed in the last 6 months o List of all training conducted on PBSP implementation, undated o Psychological Evaluation Plan, dated 9/14/11

	o Annual Psychological Update Plan, dated 9/14/11 o Positive Behavior Support Curriculum o Section K Presentation Book o Provision K Plan of Improvement (POI), dated 9/8/11 o Psychology Peer Review Committee policy and procedures, dated 3/7/11 o Individual #483's challenging behavior data sheet and replacement behavior data sheet, undated o Individual #398's requesting a break data sheet o Initial Psychological evaluation format, undated o Determination of mental retardation psychological evaluation format, undated o Psychological Evaluation update format, undated o Functional Assessment Plan, dated 9/14/11 o Group Task Force Agenda meeting minutes for 5/18/11, 8/3/11, 9/14/11 o Sample SPOs, pre and post tests, and curricula for anger management and Stars therapies o PBSP training sheets for: • Individual #215, Individual #54, <u>Interviews and Meetings Held</u>: o Charlotte Kimmel, Ph.D., Director of Psychology o Lupita Alfano, Psychology Assistant o Michael Grimmett, and Michael Miller, Psychologists o Trey Stubbs, Psychologist o Ray Mathieu, BCBA o Polly Bumpus, John Parks, Troy Miller, Bertha Allen, and Barbara Shamblin, Unit Directors o Psychology Department staff <u>Observations Conducted</u>: o Behavior Therapy Committee Meeting • Staff Present: -Charlotte Kimmel, Director of Psychology Services; Michael Grimmett, Psychologist; Molly Chase, Psychologist; Amy Diller, BCBA Consultant; Nedra Francis, Assessment Psychologist; Norvell Starling, MISD/MSSLC Liaison; Greg Creager, Psychiatrist; Chris Christensen, Psychologist; Xiaodong Zhang, Psychologist; Lupita Alfaro, Psychologist Assistant; Richard Boyer, Assistant Director of Psychology; Andrew Griffin, Psychologist; Nancy Beshear, Psychologist; Jeremy Carter, Psychologist; Gerry Reaves, Psychologist; Elizabeth Kadin, CT&D; Frances Harman, SLP • Individuals Presented: -Individual #197, Individual #508, Individual #519, Individual #385, Individual #48 o Internal Peer Review Meeting • Staff present - Charlotte Kimmel, Director of Psychology Services; Michael Grimmett,

	Psychologist; Nedra Francis, Assessment Psychologist; Xiaodong Zhang, Psychologist; Lupita Alfaro, Psychologist Assistant; Andrew Griffin, Psychologist; Nancy Beshear, Psychologist; Jeremy Carter, Psychologist; Gerry Reaves, Psychologist; Trey Stubbs, Psychologist; Ora Davis, Psychologist; Michael Miller, Psychologist; Lisa Jones, Behavior Therapist; Laurie Downey, Psychologist; Ray Mathieu, BCBA • Individual presented - Individual #183 o Anger Management group • Staff facilitators - Trey Stubbs, Psychologist; Tiffany Watson, Behavior Therapist; Christine Ortiz, DCP • Individuals participating - Individual #382, Individual #473, Individual #324, Individual #267, Individual #268, Individual #305 o Psychiatric Clinic • Staff present - Dr. Rao; Gordon Barnley, RN; Michel Boutte, Psychiatry Assistant; Zuselle Quiles, Psychologist; James Smith, QMRP; Michael Miller, Psychologist • Individual presented - Individual #386 o Psychiatric Clinic • Staff present - Dr. Creager, Psychiatrist; Molly Chase, Psychologist; Hope Wallace, RN; Dundrea Smith, QMRP; Judy Crumwell, DCP • 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: The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. In the comments section of each item of the provision, the Director of Psychology identified what tasks have been completed and the status of each provision item.

	The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. MSSLC's POI indicated compliance for items K2 and K3, and noncompliance for all other 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, the monitoring team suggests that the facility establish, and focus their activities, on short-term goals. The specific provision items that the monitoring team suggests that the facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	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 included: • Addition of a Board Certified Behavior Analyst (K1) • Increased flexibility in the data system (K4) • The use of more informative graphs (K4) • Establishment of a data collection project designed to improve reliability (K4) • Establishment of evidence-based curriculums, goal directed services, and measurable treatment objectives for psychological therapies, other than PBSPs (K8) • Improvements in Positive Behavior Support Plans (K9) • Development of a list of approved behavioral procedures at MSSLC (K9) The monitoring team suggests that the facility focus on the following areas during the next six months: • Ensure that all group and individual therapies include a fail criteria, and service plans include procedures for generalization of acquired skills (K8) • Ensure that target and replacement behavior data are reliable (K4, K10, and K12) • Begin the collection of IOA data for target behaviors (K4) • Develop a method to ensure that PBSPs are implemented with integrity (K11) • Ensure that all functional assessments include all the necessary assessment components, and have a clear summary of the variables hypothesized to affect target behaviors (K5) • Ensure 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)

#	Provision	Assessment of Status	Compliance
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). The facility, however, had made improvements in this area by the addition of a board certified behavior analyst (BCBA). Additionally, eight of the department's 19 psychologists that write Positive Behavior Support Plans (PBSP) were enrolled in course work toward becoming BCBAs. Three additional psychologists had been approved to sit for the national exam. The facility provided supervision of psychologists enrolled in the BCBA program by contracting with a consulting BCBA from the community and the new on-staff BCBA. 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 who were interviewed indicated that they had positive professional interactions with, and received professional support from, Dr. Kimmel. Finally, under Dr. Kimmel's leadership, several initiatives had 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.	The facility has continued to be in 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. The internal peer review meeting observed by the monitoring team reviewed one individual (i.e., Individual #183) and included participation by the majority of the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		psychology department. The peer review meeting included active participation among the psychologists, and resulted in the identification of several new antecedent and consequent procedures to address Individual #183's target behaviors. Review of minutes from these meetings indicated that the majority of psychologists in the department attended internal peer review meetings. Additionally, meeting minutes indicated that internal peer review meetings consistently occurred weekly, and that once a month, these meetings included a participant 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 and appeared to be appropriate and useful to the committees. 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.	The monitoring team noted some 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 to all individuals and homes at MSSLC. In the new data system, direct care professionals (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 allowed the psychologists to review data sheets and determine if DCPs were recording data at the intervals specified. The monitoring team did its own data collection reliability by sampling individual data books across all homes, and noting if data were recorded up to the previous hour for target behaviors. The results were disappointing. • The target and replacement behaviors sampled for only one (L4) of 12 homes reviewed (8%) were completed up to the previous hour. Some data sheets reviewed included data up to the previous shift (e.g., L3), however, others were missing data for the entire day (e.g.,W1, B7, and B8). • Most disturbing was the finding that in four homes. data sheets were filled out in advance, that is, they included data for times in the future. These observations indicated that DCPs were not consistently recording target behaviors. This is a serious problem because if the DCPs are not accurately recording data, the psychologists cannot evaluate the effects of their interventions.	Noncompliance

#	Provision	Assessment of Status	Compliance
		One encouraging development at MSSLC, however, was the recent establishment of a data collection pilot program in three homes, designed to improve the reliability of data collection. The pilot program included ensuring staff were trained in data collection, and providing feedback if data were not collected correctly. Data provided to the monitoring team indicated that the percentage of target and replacement behavior accurately collected had improved over the four weeks of the project. Finally, the only home that maintained timely data collection (i.e., home L4) was part of the data project. The monitoring team was encouraged by the early results of this project, and recommends that the facility extend it, and data collection reliability, to more homes. Another encouraging development was the willingness of the unit directors (supervisors of the DCPs) to work with the psychology department to improve data collection reliability. Section G1 below includes a more detailed description of the meeting between the unit directors and the monitoring team. As discussed in the last review, another method for assessing and improving the integrity with which data are collected is to regularly measure inter-observer agreement (IOA). It may be that some data systems are too complex for some DCPs to collect data reliably. Under those conditions, the data system may need to be modified (e.g., use of fewer target behaviors, move to a less complex time-sampling procedure) to ensure that the data are reliably collected. At the time of the onsite review of MSSLC, data reliability (i.e., IOA) was not collected. It is recommended that the facility ensure that IOA for all target and replacement behaviors is consistently collected in each home and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals. Another area of improvement since the last onsite review was the beginning of flexibility in data collection, and the graphing of data in increments based on individual needs (rather than all individuals' data graphed in increments of one month). For example: • Individual #398's replacement behaviors included the collection of the time of his breaks, his method of requesting the break, and his behavior following the break. • Individual #483's restraint data was graphed in hourly increments to better understand if the behaviors that provoked restraint were more likely to occur at certain times of the day. The monitoring team was encouraged by these examples of more flexible data systems and more sensitive presentations of data, however, their routine use was not apparent in observations during the onsite review. For example: • The data sheets of all of the target behaviors reviewed included only frequency	

#	Provision	Assessment of Status	Compliance
		measures. In talking to staff, it appeared that some of these behaviors might better be measured with a time-sampling or duration measure. • In both of the psychiatric clinics observed by the monitoring team, target behaviors were only graphed and presented up to the previous month. The last two weeks of data were not graphed. Up to date graphed data is a very important for proper psychiatric services to be provided. Additionally, in Individual #386's psychiatric clinic the psychiatrist wanted to evaluate his mood, however, the psychologist provided no objective data evaluating his mood. In order to achieve substantial compliance with this provision item, the psychology department will need to ensure that all treatment decisions are data-based. Specifically, they need to ensure that data accurately and reliably capture target and replacement behaviors, and demonstrate the value of data to staff by consistently graphing and presenting data in increments that encourage data-based treatment decisions. In reviewing six months of PBSP data for five individuals, three or 60% (Individual #398, Individual #113, and individual #104) indicated improvement in severe behavior (e.g., aggression or self-injurious behavior). This represented an improvement from the last onsite review when only 20% of the plans reviewed suggested improvements in dangerous behaviors. Additionally, there was some indication that when progress was not occurring, that action to address the lack of progress was occurring. For example, Individual 398's progress notes from 4/30/11 indicated that his increase in SIB and aggression may be related to staff not implementing his plan with integrity and a poor peer group. His progress note of 5/8/11 indicated that staff had been retrained and he was moved to another home. The 5/8/11 note also noted improvements in his severe behavior. On the other hand, the progress notes of the two individuals that did not demonstrate progress (Individual #591 and Individual #157) indicated no action to address the lack of progress. Additionally, none of the progress notes reviewed, PBSPs reviewed, or the list of PBSPs, indicated that modification of the PBSP <u>ever</u> occurred other than at the annual review. Clearly, the lack of treatment progress is not likely to be solely the result of an ineffective PBSP, however, the monitoring team does expect that the progress note or PBSP would indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred if an individual was not making expected progress. The monitoring team will continue to monitor the progress of target behaviors as one measure of the effectiveness of PBSPs, and behavior systems in general, at the facility.	
K5	Commencing within six months of the Effective Date hereof and with	This provision item was rated as being in noncompliance due to the absence of initial (full) psychological assessments for each individual and the lack of comprehensiveness	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	of many of the psychological assessments reviewed. Additionally, not all individuals with a PBSP had a functional assessment, and many of the functional assessments were found to be incomplete. <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 was (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 of individuals with psychological assessments indicated that 240 of the 391 individuals at MSSLC (61%) had an initial psychological assessment (i.e., determination of mental retardation). This represented an improvement from the last review when 78 individuals had initial psychological assessments. Twelve of the 162 initial psychological assessments completed since the last review (7%) were reviewed: • Three (Individual #554, Individual #324, and Individual #207) of 12 initial psychological assessments reviewed (25%) were considered complete and included a standardized assessment of intellectual and adaptive ability, a review of personal history, and a review of behavioral/psychiatric and medical status. • Nine (75%) contained a standardized assessment of intellectual and adaptive ability, a review of personal history, and a review of behavioral/psychiatric status (i.e., missing medical status). Each individual's record should contain an initial 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. A spreadsheet of functional assessments completed since the last review indicated that 12 were completed. Nine of these functional assessments (75%) were reviewed to assess compliance with this item of the Settlement Agreement. As discussed in the last report, the functional assessments included all of the components commonly identified as necessary for an effective functional assessment. The quality of some of these components, however, was insufficient for the functional assessments to be as effective	

#	Provision	Assessment of Status	Compliance
		as they should be. All functional assessments should include direct and indirect assessment procedures. A direct assessment consists of direct observations of the individual and documentation of antecedent events that occurred prior to the targets behavior(s) and specific consequences that were observed to follow the target behavior. Indirect assessments help to understand why a target behavior occurred by conducting/administrating questionnaires, interviews, or rating scales. All nine of the functional assessments reviewed indicated that direct and indirect assessments occurred, and all functional assessments reviewed (100%), included appropriate indirect functional assessments. As discussed in the last report, however, the majority of functional assessments reviewed did not present data from those direct assessments. The direct functional assessments for seven (i.e., Individual #466, Individual #392, Individual #398, Individual #222, Individual #104, Individual #157, and Individual #113) of the nine assessments reviewed (78%), were rated as incomplete because they did not specify antecedents prior to the target behavior(s) and/or consequences after it occurred. In other words they were not helpful in understanding the potential variables affecting undesired behavior. For example: • Individual #104's direct functional assessment consisted of direct observations, but it did not include an observation of the target behaviors and, therefore, did not provide any additional information about relevant antecedent or consequent events affecting the target behavior. As discussed in the last report, one 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 order to be useful, however, ABC data need to be collected for a duration long enough to observe several examples of the of the target behavior, so that patterns of antecedents and consequences could be identified. • Individual #222's direct functional assessment was described as a functional analysis, however, it appeared to be a discrimination training session. Although this session appeared to be an appropriate way to teach Individual #222 to better discriminate between food and non-food items, it was not clear what additional information about relevant antecedent or consequent events affecting the target behavior was gained by this procedure and, therefore, it was judged to not be a good example of a direct functional assessment. On the other hand, the following direct functional assessment appeared to be particularly useful for identifying potential variables affecting the target behavior: • Individual #483's direct functional assessments included an analysis of time of the day and self-injurious behavior (SIB) to determine if the behavior was more	

#	Provision	Assessment of Status	Compliance
		likely to occur at particular times. This direct assessment revealed that Individual #483's SIB was most likely to occur at times when snacks and medications were presented. All functional assessments should include direct functional assessments that include target behaviors and provide additional information about the variables affecting the target behavior. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This was an improvement from the last review when 73% of the functional assessments reviewed did not identify potential antecedents and consequences. As discussed in the last report, when comprehensive functional assessments are conducted there are going to be some variables identified 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 (i.e., direct and indirect assessments) into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. Four functional assessments reviewed (44%) did not include a summary statement (i.e., Individual #222, Individual #157, Individual #113, and Individual #104). This represented a slight improvement from the last review when 50% of the functional assessments reviewed did not have a clear summary statement. The following represents an example of a good summary statement: • Individual #466's functional assessment included a summary statement that included a clear hypothesis that Individual #466's undesired behaviors were maintained by social attention and escape. The summary statement went on to hypothesize that allowing Individual #466 to occasionally escape or receive attention following his target behaviors was what was maintaining the target behavior. This summary statement was particularly useful because it led to potential future interventions, such as the use of time-out (as suggested in the summary statement), and the retraining of staff. 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. As reported in the last review, there was evidence that functional assessments at MSSLC were reviewed and modified when an individual did not meet treatment expectations. Individuals #183 and 398's functional assessments indicated that they were revised at least once since they were originally written. It is recommended that when new	

#	Provision	Assessment of Status	Compliance
		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). One (Individual #483) of the nine functional assessments reviewed (11%) was evaluated to be comprehensive and clear. This represented a slight improvement over the last report when none of the functional assessments reviewed were evaluated as acceptable. Several functional assessments, however, contained excellent components that should be modeled for future reports. Those include: • Good comprehensive summary statements for Individual #466. • Good description of potential antecedents affecting target behaviors for Individual #157.	
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 initial (full) psychological assessments were not complete (see K5) and, therefore, this provision item was rated as being in noncompliance. Although all of the intellectual assessments that were reviewed were current, a review of the spreadsheet of initial psychological assessments indicated that 125 of the 240 (52%) were not conducted in the last five years. Psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	In addition to the initial or full psychological assessment, an annual update should be completed each year. The purpose of the annual psychological assessment, or update, is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should contain the elements identified in K5 and 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. Annual psychological assessments (updates) were completed for 29 of the 393 (7%) of the individuals at MSSLC. This represented an improvement from the last review when only 11 individuals had annual psychological assessments. The monitoring team reviewed nine of the 18 (50%) annual psychological assessments completed since the last review to assess their comprehensiveness: • Four (Individual #451, Individual #583, Individual #144, Individual #550) of nine annual psychological assessments reviewed (44%) were considered complete and included an assessment or review of intellectual and adaptive ability, a review of personal history, and a review of behavioral/psychiatric and	Noncompliance

#	Provision	Assessment of Status	Compliance
		medical status. • Five (56%) contained a standardized assessment of intellectual and adaptive ability, a review of personal history, and a review of behavioral/psychiatric status, but did not include a review of medical status. In order to achieve compliance with this item of the Settlement Agreement, all individuals at the facility will need to have annual psychological assessments and they need to contain all of the components described in K5. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of two recent admissions (Individual #424 and Individual #33) to the facility indicated that this component of this provision item continued to be 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. This was an area in which the facility had made many improvements since the last onsite review. These improvements included: • The establishment of task force to improve psychological services • The use evidence-based curriculums • Development of a new treatment planning and evaluation process • The use of pre and post tests to objectively assess progress Although these improvements were very encouraging, some were not completely implemented at the time of the onsite review. Therefore, this provision item was rated to be in noncompliance. 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. One hundred and sixty-three individuals were receiving psychological services at MSSLC at the time of the onsite review. The facility continued to consistently document the need for psychological services other than PBSPs in psychological assessments (e.g., Individual #550), and/or PBSPs (e.g., Individual #451). The monitoring team attended an anger management group therapy session, reviewed program documentation, and spoke with the psychologist who led the session. The group appeared to be very well organized and had clear objectives for the session. After	Noncompliance

#	Provision	Assessment of Status	Compliance
		the class, the psychologist leading the group presented the curriculum and objectives to the monitoring team. He also shared examples of individual objectives based on the format used for other skill acquisition plans at the facility (specific program objectives, or SPOs). Because the use of individual objectives was recently introduced, not all participants had them at the time of the onsite review. Additionally, progress notes based on the individual objectives were not available. It is recommended that the facility continue with its efforts to ensure that all counseling/ psychotherapy services 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 Finally, the monitoring team suggests 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 resistant to less formal interventions. By fourteen days from obtaining necessary	All PBSPs reviewed had the necessary consent and approvals. This item was rated as being in noncompliance because not all PBSPs reviewed contained adequate use of all of the components necessary for an effective plan, and many of the interventions were not clearly based on functional assessment results. Thirty-five PBSPs were written or revised since the last onsite review, and 15 of these (43%) were reviewed to evaluate compliance with this provision item. All of the necessary components of a PBSP were included in the PBSPs (or in the accompanying functional assessments) reviewed. All PBSPs reviewed included descriptions of target behaviors, however, six (40%) of these (i.e., Individual #591, Individual #385, Individual #508, Individual #451, Individual #153, and Individual #353) were not operational. This represented a decline in operational definitions from the last review when 20% of PBSPs were rated as not having operational definitions. Examples of definitions that were not operational include:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Individual #153's PBSP defined physical aggression as "… hitting, kicking, pushing…. another person with the intent to cause harm." This definition required the reader to infer if Individual #153 did indeed have an intention to injure someone as opposed to hitting him or her. An operational definition should not require DCPs to infer an individual's intentions. An operational definition should only include observable behavior (e.g., hitting or kicking others). • Individual #591's PBSP included a target behavior of unauthorized departure that included "Deliberately breaking assigned supervision…." On the other hand, the following is an example of PBSP that contained operational definitions that were operational, clear, and complete: • Individual #483's physical aggression was defined as "…attempting to or actually hitting, kicking, punching, scratching, grabbing, or biting another person." All PBSPs should include operational definitions of target behaviors. All 15 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but four (i.e., Individual #591, Individual #225, Individual #153, and Individual #353) of the 15 reviewed (27%) identified antecedents and/or consequences that did not appear to be consistent with the stated function of the behavior and, therefore, were not likely to be useful for weakening an undesired behavior. This did, however, represent an improvement from the last review when 65% of PBSPs reviewed had antecedent or consequence interventions that were rated to not be useful for decreasing target behaviors. Examples of interventions not related to the hypothesized function were: • Individual #591's PBSP hypothesized that his physical aggression may have been maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). His intervention, however, following target behaviors included placing him in time out (e.g., in his bedroom). If his aggression was maintained by negative reinforcement, then this intervention would likely encourage, rather than discourage, his physical aggression because it allowed him to escape unpleasant activities by engaging in the target behavior. On the other hand, removing the hypothesized source of the aggression BEFORE the target behavior occurred would represent a good antecedent procedure. Unfortunately, the antecedent procedures in Individual #591's PBSP did not include encouraging him to escape and/or avoid (whenever practical) undesired activities by engaging in desired behaviors (e.g., asking for a break). Ideally, after the aggression occurs, Individual #591 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of the	

#	Provision	Assessment of Status	Compliance
		aggression is such that it is dangerous to maintain him in the activity following aggression, however, then the PBSP should specify his return to the activity when he is calm, and again encourage him to escape or avoid the demand by using desired forms of communication. The point is that the PBSP should clearly state that staff should encourage Individual #591 to use desired forms of communication to tell us when he wants to terminate, or have a break from, an activity. Once the target behavior occurs, it may be necessary to remove the source (i.e., the undesired activity) for safety reasons. The PBSP, however, needs to clearly state that removal of the undesired activity should be avoided whenever possible, because it encourages future aggressive behavior. • Individual #225's PBSP hypothesized that his physical aggression was maintained by attention. The intervention following aggression, however, included assisting him to practice relaxation techniques that appeared to require a considerable amount of staff attention. If his aggression was maintained by attention, this intervention would likely result in an increase in the target behavior. An alternative procedure, that would be more consistent with the hypothesized function, would be to attempt to redirect him, but minimize the attention until the physical aggression ends. An example of a PBSP where both antecedent and consequent interventions appeared to be based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior was: • Individual #491's PBSP hypothesized that her physical aggression functioned primarily to gain staff attention. Antecedent interventions included providing attention whenever Individual #491 appeared to be seeking it, was compliant with simple tasks, and at least every hour in which aggression did not occur. Her intervention following physical aggression included asking her to relax, but specified that staff only ask her what she needs after she was calm and able to speak at a normal pitch and volume. 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. Replacement behaviors were included in all 15 PBSPs reviewed. Replacement behaviors should be functional (i.e., should represent desired behaviors that serve the same function as the undesired behavior) when possible. That is, when the reinforcer for the target behavior is identified and providing the same reinforcer for alternative behavior is practical. The monitoring team found that seven of 10 (70%) of the replacement behaviors that practically could be functional, were functional. Nonfunctional replacement behaviors were found in Individual #591's, Individual #48's, and Individual	

#	Provision	Assessment of Status	Compliance
		#153's PBSPs. This is consistent with the percentage of replacement behaviors judged to be functional in the last report. An example of a replacement behavior that was not functional included: • Individual #591's targeted behaviors were hypothesized to be primarily maintained by negative reinforcement. His replacement behavior consisted of following instructions. Following instructions may represent an important skill for Individual #591, however, it was not functionally equivalent to the purposed function of his target behaviors, that is, escaping or avoiding undesired activities. An example of a more functional replacement behavior would be to teach him an appropriate way to postpone or terminate an undesirable activity. If practical, this would represent a good example of a functionally equivalent replacement behavior because it provides the same reinforcer (i.e., a way to escape non-preferred activities) as hypothesized to be maintaining his target behaviors. Six of the seven functional replacement behaviors discussed above (86%) appeared to represent behaviors that staff needed to complete rather than skills the individual needed to acquire. For example • Individual #451's replacement behavior was increasing appropriate communication. The PBSP included instructions for staff to ask Individual #451 to speak more slowly and use his communication device. In contrast, one example of a functional replacement behavior that appeared to include the acquisition of a new skill was: • Individual #157's replacement behavior consisted of teaching him strategies for better gaining others attention, managing conflict, etc. It is recommended that replacement behaviors that require the acquisition of new behaviors include specific program objective (SPO) plans for training. Moreover, these plans should be included into the current methodology, data system (when appropriate), and schedule of implementation for other SPOs at MSSLC. 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, seven (Individual #483, Individual #398, Individual #157, Individual #104, Individual #491, Individual #197, and Individual #519) of the 15 PBSPs reviewed (47%) represented an example of a complete plan that contained operational definitions of target behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented an improvement over the last review when 25% of the PBSPs reviewed were judged to be acceptable.	

#	Provision	Assessment of Status	Compliance
		Finally, in past reviews, staff expressed confusion as to what interventions they could and could not implement to decrease undesired behavior. In response, the facility has recently developed a list of interventions that were allowed (and the conditions necessary to implement them) and those that were prohibited. The monitoring team is encouraged by the overall progress in the quality of PBSPs at MSSLC, and looks forward to continued improvements in this provision item.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Interobserver agreement measures were not collected for target and replacement behaviors at the time of the onsite 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 achieving substantial compliance of this provision item. Target and replacement behavior were consistently graphed monthly at MSSLC. As discussed in K4, 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 the changes associated with a change in medication or target behaviors), however, it was not obvious that these graphs were used to make data-based decisions. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path. It is recommended that all graphs contain clear demarcation of changes in medication, health status, or other relevant events.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	This provision item was rated as being in noncompliance because, 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 monitored the reading level of each PBSP and had 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. The integrity data should be tracked and reviewed regularly, and minimal acceptable integrity measures established. As discussed in the last report, MSSLC had introduced a training tool 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		PBSPs. There were, however, no integrity data available for review during the onsite review. The monitoring team looks forward to reviewing integrity data during the next onsite review.	
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 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.	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 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 need to present documentation that every staff assigned to work with an individual has been trained in the implementation of his or her 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.	Noncompliance
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 391 individuals and employed 19 psychologists responsible for writing PBSPs. Additionally, the facility employed 10 psychology assistants and six psychology technicians. One of these psychologists had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least 13 psychologists with BCBAs.	Noncompliance

Recommendations:

1. Ensure that all psychologists who are writing Positive Behavior Support Plans (PBSPs) attain BCBA certification (K1)
2. The facility should extend the data project, and data collection reliability, to more homes (K4)
3. It is recommended that the facility ensure that IOA for all target and replacement behaviors is consistently collected in each home and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals (K4)

4. It is recommended that the facility continue to expand the flexibility of the collection of target and replacement behaviors to ensure that all measures are sensitive to individual needs (K4).

5. Data should be graphed in increments that allow data-based treatment decisions. Additionally these graphs should be consistently available when treatment/medication decisions are made (K4, K10).

6. If an individual is not making expected progress, the facility should ensure that their progress note indicate that some activity to address the lack of progress (e.g., retraining of staff, additional functional assessment, modification of the PPBSP, etc.) had occurred (K4).

7. Each individual's record should contain an initial 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 (K5)

8. Psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K6)

9. All individuals at the facility need to have annual psychological assessments and they need to contain all of the components described in K5 (K7)

10. All individuals with a PBSP should have a functional assessment of the variable or variables affecting the individual's target behaviors (K5)

11. All functional assessments should include direct functional assessments that include target behaviors and provide additional information about the variables affecting the target behavior (K5)

12. 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 (K5)

13. 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) K5

14. The facility should continue with their efforts to ensure that all counseling/ psychotherapy services 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 (K8)

15. All PBSPs should include operational definitions of target behaviors (K9)

16. 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 (K9)

17. Replacement behaviors that require the acquisition of new behaviors should include specific program objective (SPO) plans for training (K9)

18. It is recommended that a treatment integrity system is collected, data regularly tracked, and minimal acceptable integrity scores established (K11).

19. The facility should provide 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. This training should include a competency-based component. 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 (K12).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 2/16/11 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 #044.2: Emergency Response, 9/7/11 o DADS Policy #003: Quality Enhancement, 11/13/09 o MSSLC POI for Section L o MSSLC Organizational Charts o MSSLSC Medical Services Policy, 8/11 o MSSLC Policies and Procedures Manual, Medical -8, Referrals to Alternative Healthcare Facilities for Non-Emergency Medical Services, 3/15/11 o MSSLC Home Life and Training Manual, Nursing Sevices-EP12, Seizure Management, 3/1/11 o MSSLC Quality Assurance, 4/1/11 o Mortality Recommendations Log o Listing, Individuals with seizure disorder o Listing, Individuals with pneumonia o Listing, Individuals with a diagnosis of osteopenia and osteoporosis o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Females over age 40 with dates of last mammogram o Listing, Females over age 18 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders o Listing, Individuals hospitalized and sent to emergency department o Report of external medical reviews conducted in June and September 2011 o Report of internal medical reviews conducted June 2011 o Medical caseload data o Presentation Book for Section L o Medical Review Committee Summaries: 3/23/11, 3/16/11, 3/30/11, 4/13/11, 4/20/11, 4/27/11, 5/4/11,5/11/11, 5/18/11, 5/25/11, 6/6/11, 6/8/11, 6/15/11, 6/22/11, 6/29/11, 7/6/11, 7/13/11, 7/20/11, 7/27/11, 8/3/11, 8/10/11, 8/17/11, 8/24/11 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, quarterly medical summaries, 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 #575, Individual #311, Individual #448, Individual #432, Individual #335, Individual #587, Individual #26, Individual #538, Individual #524, Individual #249 o DNR documentation for Individual #515 <u>Interviews and Meetings Held</u>: o Dolores Erfe, MD, Medical Director o Christopher Ellis, MD, Primary Care Physician o Gabriel Tarango, DO, Primary Care Physician o Robert Brown, MD, Primary Care Physician o Scott Davis MD, Primary Care Physician o William E. Thomas, Physician Assistant o Kendall Brown, MD, Psychiatrist o Madhu Rao, MD, Psychiatrist o Erica Swicegood, MD, Psychiatrist o Greg Creager, MD, Psychiatrist o Norris Buchmeyer, RN, Chief Nursing Executive o Karen Wilson RN, QA Nurse <u>Observations Conducted</u>: o Daily Clinical Services Meeting o Medical Review Committee o PSP meeting, 9/20/11 o Risk Discussion with PST for Individual #524
	Facility Self-Assessment: The facility updated the POI on 9/8/11 and determined that it was not in compliance with any of the provision items for Section L. This assessment was congruent with the findings of the monitoring team. The POI provided a paucity of information regarding compliance activities. It briefly mentioned changes in Medical QA audit tools, but it did not provide data from the audits nor state if information from these audits was utilized to determine the rating of noncompliance. An action plan was also included in the POI. This plan addressed only provision L3. Three steps focused on the quality record audits, but did not provide a plan or action steps that would result in implementation of a medical quality improvement program. Although the facility rated itself noncompliant with the other provisions, it offered no specific steps that would be taken to move towards achieving compliance. Self–assessment of compliance will require that the facility engage in a number of activities and utilize information and data from multiple sources. Although the POI provided very little information related to the self-assessment, multiple data streams were available that had the potential to provide some objective assessment of compliance status.

	The monitoring team agreed with the facility's assessment of noncompliance based on evidence of issues related to the provision of preventive and routine services, inadequate follow-up of abnormal studies, a lack of reviews that assessed clinical outcomes, a lack of a formal medical quality program and the absence of clinical guidelines.
	Summary of Monitor's Assessment: The medical department continued to face the challenges related to having a medical staff largely comprised of locum tenens physicians. The department benefited from the leadership of a long-term medical director. All other physicians providing services were temporary, locum tenens providers. There was one physician assistant who had recently taken on the primary responsibility for a caseload. All of these practitioners appeared eager to meet the needs of the individuals. Generally, the medical staff responded to the acute and chronic needs of the individuals. Problems were noted with the provision of certain preventive care services. Records reviewed also indicated that follow-up was at times inadequate as abnormal findings and/or results sometimes were not addressed for many months. The department implemented several databases that should have provided the ability to track services and ensure consistent care. At the time of the visit, it appeared that the databases were not fully functional or that data entry was problematic. The department had not developed any clinical guidelines since the last visit, other than the laboratory matrix, which was intended to establish the criteria for monitoring, associated with drug use. It also included some guidance relative to preventive services. In the absence of established clinical guidelines, development of a robust medical quality program will be difficult to create. External medical reviews were completed, deficiencies identified, and corrective actions implemented. The medical department also audited five records each month using the external audit tool. Both of these evaluations were process driven. The actual clinical outcomes were not assessed.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the documents reviewed section. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in sub-sections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Overview** The medical staff was comprised of a full time medical director, four locum tenens	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	physicians and one physician assistant. An adequate agreement was in place between the physician assistant and the supervising physician. Four locum tenens physicians provided psychiatric services. During the March 2011 visit, there were six primary care physicians. Of the current four physicians, two were new to the facility. The medical staff attended the daily clinical services meeting at 8:30 am. This meeting was attended by department heads from multiple disciplines and was used as a collaborative means of reviewing events that occurred over the previous 24 hours. The medical director facilitated this meeting, which was also attended by the interim facility director. It appeared to present opportunities for speedier resolution of some clinical, as well as non-clinical, issues. The meeting was brief, lasting approximately 30 minutes. PCPs conducted clinic daily starting around 9:00 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. 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. The digital images were read within 24 hours and reports could be available in 30 minutes for stat x-rays. EKGs were transmitted to Scott and White. If abnormalities were found, the cardiologist provided a written report. The facility conducted podiatry clinic onsite. All other specialty services were received at community facilities. Individuals who required acute care or admission were transferred to a local hospital. The facility maintained a hospital liaison program through nursing services. In addition to clinical duties, the primary care providers also participated in PSP meetings and PSPAs. The monitoring team attended the PSP held Tuesday morning 9/20/11. It was good to see the PCP fully engaged in the support planning process. The monitoring team was particularly encouraged that the PCP did not simply provide medical data, but rather engaged in meaningful discussion with the individual on the risks associated with adverse health behaviors. Moreover, the PCP discussed how these adverse health behaviors served as barriers to achieving the individual's desired stated goals. **General Medical Care and Documentation** Individuals were provided a wide array of preventive, routine, and specialty services. Acute care services were provided at several local facilities. The medical staff responded to the needs of the individuals. Notwithstanding these efforts, there were significant issues identified with the provision of care that had the ability to negatively	

#	Provision	Assessment of Status	Compliance
		impact health outcomes. Gaps were noted in the provision of some preventive services, follow-up of chronic issues, and abnormal diagnostics. These lapses were frequently associated with changes in medical staffing. Several of the requirements of the Health Care Guidelines are discussed below. Examples of findings related to the requirements are provided in the case reviews documented later in this section. <u>Annual Medical Assessments</u> Current annual medical summaries were found in all but one record included in the sample. The quality of the summaries varied among the medical staff. In most instances, there was no interval history. The past medical history was a series of bulleted items, such as diagnostics completed and interval illnesses. The plan of care very often consisted of statements, such as "continue meds" or "follow-up with neurology." When considering the format of the Annual Medical Summary, a few key issues should be addressed: • Interval history- 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. o 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. • Immunizations should be noted in the assessment. • Preventive care requirements and screenings should be documented and include dates. • The active problems should be listed along with a plan of care that addresses each problem. The reader should be provided adequate information on overall management. The Quarterly Medical Summary would provide the interval update. <u>Active Problem List</u> The Active Problem Lists were noted in the records, but very few were updated appropriately. <u>Integrated Progress Notes</u> Medical providers documented in the integrated progress notes. The notes were usually timed, dated, and signed. Documentation was not consistently completed in the required SOAP format. Some notes were illegible. Pre-hospital transfer notes were not	

#	Provision	Assessment of Status	Compliance
		consistently completed. The post-hospital notes were completed using a template. There was no designated place for a date or signature resulting in frequent absence of this information. Documentation of abnormal findings and diagnostics was very provider-specific. There were very few documented responses to the QDRRs. Consultation summaries and lab results were frequently missing. <u>Quarterly Medical Summaries</u> Quarterly summaries were found in very few records. Four summaries were found among the 10 records. One record indicated that the summary had been dictated, but it was not present in the records provided. When present, the information provided a good snapshot of the major interval problems. <u>Physician Orders</u> Physician orders were usually signed, timed, and dated. Several were noted to be incomplete. This usually involved a missing indication or stop dates. Rarely did the orders provide monitoring parameters as required in the Health Care Guidelines. **Routine and Preventive Care** Routine and preventive services were available to all individuals supported by the facility. Vision and hearing screenings were provided with high rates of compliance. The core vaccinations were usually provided to individuals with the exception of those who refused. Other preventive services and immunizations were provided, but consistency was not always evident. <u>Immunizations</u> • 10 of 10 (100%) individuals received pneumococcal and yearly influenza vaccinations • 9 of 10 (90%) individuals received vaccination against Hepatitis B Documentation of varicella vaccination remained inconsistent. The Zoster vaccination was provided to individuals age 50 and older. Pharmacy and Therapeutic Committee meeting minutes documented that the vaccine would be provided. The rationale for starting at age 50 was not noted. The current CDC recommendation is to provide a one-time dose to individuals age 60 and older. The CDC currently does not have a recommendation for routine use of the shingles vaccine for persons age 50 to 59. The vaccination is, however, approved for use in persons age 50 and older.	

#	Provision	Assessment of Status	Compliance
		Screenings • 9 of 10 (90%) records contained documentation of appropriate vision screening • 9 of 10 (90%) records contained documentation of appropriate hearing testing o 1 individual refused testing Prostate Cancer Screening • 2 of 4 males met criteria for PSA testing • 2 of 2 (100%) males had appropriate PSA testing Breast Cancer Screening • 6 of 6 females met criteria for breast cancer screening • 4 of 6 (67%) females had current breast cancer screenings • 2 of 6 (33%) females had screenings done within the past two years A list of females age 40 and older, date of last mammogram, and reasons for noncompliance was provided. The list contained 71 individuals. • 39 of 71 (55%) individuals had current breast cancer screenings • 12 of 71 (17%) individuals were age 70 or greater and mammography was discontinued at the discretion of the physician, per protocol • 12 of 71 (17%) individuals refused mammography • 1 of 71 (1%) individuals had study cancelled • 7 of 71 (10%) individuals did not have current screenings and had no specific reason o 4 of 7 individuals had pending appointments o 1 of 7 needed an MD order o 2 of 7 was listed "NA" Cervical Cancer Screening • 5 of 6 females met criteria for cervical cancer screening • 0 of 5 (0%) females completed cervical cancer screening within the past year • 5 of 5 (100%) females completed cervical cancer screening within the past three years o 1 individual was known to be high risk A list of all females age 18 and older was provided. The list contained 79 individuals and dates of last pap smears. The ages of each individual and risk classification was not listed. • 6 of 79 (8%) had cervical cancer screenings completed in 2011 • 53 of 79 (67%) completed screenings within the past 3 years	

#	Provision	Assessment of Status	Compliance
		• 20 of 79 (%) had not completed screenings within the past 3 years The exact determination of compliance with this requirement must include assessment of risk. Cervical cancer screening for those at low risk may be completed every three year if certain requirements are met. <u>Colorectal Cancer Screening</u> • 5 of 10 (50%) individuals met criteria for colorectal cancer screening • 0 of 5 (0%) individuals had undergone colonoscopy for colorectal cancer screening A list of individuals, age 50 and older, was provided. The list contained 74 individuals. • 30 of 74 (40%) of individuals had completed colonoscopies o 21 of 30 (70%) were screening colonoscopies o 9 of 30 (30%) were diagnostic colonoscopies • 44 of 74 (60%) of individuals had not completed a screening colonoscopy The report submitted clarified that according to the Health Care Guidelines, screening colonoscopies for individuals 50 and older, with no family history, would be done every 10 years. <u>Additional Discussion</u> The format of the preventive care flow sheet had not been updated. The medical director reported that a preventive services policy had been drafted by state office, but had not been approved. Many of the preventive care flow sheets submitted were not readable. A laboratory matrix was developed and approved by the P&T Committee in March 2011. This matrix contained lab monitoring parameters for the use of certain drugs as well as some preventive care requirements. In several instances, the guidelines cited in the matrix were not consistent with the Health Care Guidelines. For example, the matrix stated colonoscopy was to be done for those 50 and older <u>every five years</u>. The Health Care Guidelines cited a frequency of every 10 years. Similar inconsistences were noted with regards to prostate and breast cancer screenings. The lab matrix added the requirement for completion of a baseline BMD study on every individual regardless of risk assessment. Annual TSH testing was required for all individuals. Since the last onsite review, a database for tracking breast and colorectal cancer screening was implemented. The facility data cited above was generated by this database. Additional reviews of other documents, however, proved that this information	

#	Provision	Assessment of Status	Compliance
		was inaccurate. There were individuals noted in the record sample that should have been included in the various lists, but were not. Examples are provided in the case reviews. Data related to osteoporosis is discussed later in this section. **Medical Management** <u>Diabetes Mellitus</u> • One individual in the record sample had a diagnosis of diabetes. Management is presented in the case review section for Individual #538. <u>Osteoporosis</u> • 4 of 10 (40%) individuals had a diagnosis of osteoporosis • 3 of 10 (30%) individuals had a diagnosis of osteopenia • 7 of 7 (100%) individuals received calcium supplementation • 7 of 7 (100%) individuals had recent documentation of Vitamin D levels • 6 of 7 (86%) individuals received Vitamin D supplementation • 3 of 7 (43%) individuals received treatment with Alendronate • 3 of 7 (43%) individuals received an injection of Reclast • 7 of 7 (100%) individuals had BMDs within the past two years All of the individuals included in the record sample benefited from appropriate treatment of osteopenia and osteoporosis. Documentation of the treatment, however, was not readily evident. For those individuals who received the Reclast injection, documentation was not found in the quarterly summaries or active problem lists. This significant treatment must be accurately recorded. A consultant reviewing limited records would likely not know that the individual was appropriately treated for osteoporosis. A list of all individuals with a diagnosis of osteoporosis and osteopenia and their medication regimens was requested. A drug report with indications was submitted in response to this request. This list contained 29 individuals with a diagnosis of osteopenia and two individuals with a diagnosis of osteoporosis. Only one of the seven individuals in the record sample was included in the list. Data contained in the Medical Review Committee notes indicated that numerous individuals were approved to have off campus treatment with Reclast. This treatment was not documented on the MAR. Because this treatment was provided off campus, the medication was not captured in the pharmacy report. It should also be noted that during the March 2011 review, 79 individuals were reported to have osteoporosis or osteopenia. This further affirms the inaccuracy of data reported.	

#	Provision	Assessment of Status	Compliance
		Case Reviews Individual #311 had multiple problems including intractable seizure disorder, osteoporosis, GERD, and dysphagia. There were multiple issues identified with the care of this individual: • This individual was hospitalized with dilantin toxicity. • During the weeks preceding hospitalization, there were multiple occasions when the drug levels were high and orders were written to hold the medication. The individual was seen by the physician several times. Eventually, the individual became somnolent and required transfer to an acute care facility for treatment in the intensive care unit. The neurology note dated 6/13/11 noted that unfortunately, dilantin levels had been inconsistent and this would require tapering the dilantin and starting Keppra. o On 2/19/11, a prehospital transfer note was documented. Upon return on 2/14/11, the post-hospital form was completed. It listed dilantin levels only and was not signed or dated. A more detailed note was written on 2/15/11. • Fecal occult blood testing was completed for colorectal cancer screening. No colonoscopy had been completed and this individual did not appear on the list of persons age 50 and greater who required colonoscopy. • This individual had a ferritin level of 22 on 6/13/11. There was no documentation of this in the IPN and no follow-up was performed. Although this was just a minimally low level, follow-up was warranted to rule out true iron deficiency. • This individual had a diagnosis of osteopenia, but did not appear on the osteoporosis list. Vitamin D and calcium were given. The BMD was monitored, per protocol. • The Annual Medical Summary noted that a tetanus booster was given in 2000, but the plan of care did not address the need to re-administer. All other immunizations were appropriately provided. • This individual received the Zoster vaccination. • The Active Problem List was not updated. • The QDRR noted on 5/20/11 that a current MOSES evaluation was not present in the record. It also suggested the dilantin toxicity may have been due to a severe drug interaction. • Mammography was completed in 2010 and the last cervical cancer screening was in 2008. • Quarterly medical summaries were not found in the records. An IPN note on 6/29/11 documented that the Quarterly Medical Summary was dictated.	

#	Provision	Assessment of Status	Compliance
		Individual #448 had moderate MR, periodontal disease, and cataracts. Observations noted related to care included: • The individual received some, but not all, of the required preventive services. This was due to a pattern of refusing medical care. The PCP had an opportunity to examine the individual when the individual desired some element of care. • A lipid panel showed slightly elevated values that the PCP discussed with the individual. Treatment was refused. • The individual had poor oral hygiene and periodontal disease. Dental treatment was usually, but not always, refused. On 9/12/11, the individual cooperatively allowed scaling and cleaning, but refused further treatment. The PSP documented discussion of refusals, but elected not to attempt desensitization. • A Quarterly Medical Summary was present in the record and the Active Problem List was updated. Individual #575 had a history of mild MR, conduct disorder and multiple adverse health behaviors. Observations related to care included: • The individual received all appropriate preventive care. • Vaccinations were appropriate and the Annual Medical Summary listed key vaccinations and follow-up antibodies when indicated. The Quarterly Medical Summary provided a concise interval summary that included the interim history, consultations, labs, and medications. • Physician orders were timed, dated, and signed. • Abnormal findings were documented in the IPN. • The individuals' weight loss was addressed in a timely manner. • The individual received regular dental treatment, but had fair oral hygiene. This may have been partly due to wearing a dental appliance. • The Annual Medical Assessment clearly documented the PCPs efforts to counsel the individual about adverse health behaviors. Individual #335 had osteoporosis, hyperlipidemia, seizure disorder, intermittent explosive disorder, hypertension, and Vitamin D deficiency. • Vaccinations, screenings and preventive care were provided. • Dilantin was increased, but no level was checked. The level on 6/8/11 was not therapeutic. The individual appeared to refuse the medication. This was referred to the PST who believed this was not a recurrent pattern. • The Annual Medical Summary did not provide an appropriate plan of care to address the problems. The plans were typically noted to be "continue current treatment." • A DEXA, dated 2/25/11, commented that BMD was so low that secondary	

#	Provision	Assessment of Status	Compliance
		causes of bone loss should be explored. This report was initialed, but not dated. There was no note in the IPN and this was not addressed. Treatment for osteoporosis included alendronate, vitamin D, and calcium. The Vitamin D level was monitored. • On 7/28/11, another PCP noted persistently elevated alkaline phosphatase levels and requested an abdominal ultrasound. The study, completed on 8/15/11, showed questionable dilation of intra-hepatic ducts and suggested that additional studies might be warranted. This recommendation was documented in the IPN on 8/16/11 to be considered and discussed with the medical director. • On 8/31/11, another primary provider documented that the ENT and colonoscopy reports were reviewed. The individual had an incomplete colonoscopy on 8/22/11 due to poor bowel prep. The plan was to recheck stools. • A ferritin level of 10.9 was recorded on 10/13/10. The individual was started on iron supplementation. There was no follow-up until 2/17/11 at which time the ferritin was within normal range. The colonoscopy may have been requested as part of the work-up to determine the source of iron deficiency, but there was a significant lapse in time before this was done. The records did not indicate the etiology of the iron deficiency. Attention to these issues was managed by several physicians over a 10-month period. • Given the serious nature of a diagnosis of iron deficiency in a male, this problem must receive immediate follow-up if that has not already occurred. Individual #26 had the diagnoses of seizure disorder, meningioma, and chronic headaches. The following observations were noted through record review: • Most vaccinations and preventive services were appropriately provided. There was no documentation of immunity to varicella. There was no current lipid profile in the labs and the preventive care flow sheet was not readable. • The active problem list was not updated and excluded the diagnoses of chronic headaches and lipoma. • The neurology note dated 9/24/10 documented that a recommendation to start Topamax for headaches was made during clinic visit of 2007, but that never happened. The individual continued to complain of headaches. • On 4/1/11, the individual was seen in Neurology clinic for routine follow-up and was noted to be doing fairly well. A soft tissue mass was noted on the posterior neck. The primary physician was asked to evaluate. The IPN documented the assessment and determination of a lipoma. • The individual had a diagnosis of osteopenia, but was not included in the osteoporosis list. Treatment was appropriately rendered with calcium and	

#	Provision	Assessment of Status	Compliance
		Vitamin D supplementation. Vitamin D was periodically monitored. The last DEXA scan was in September 2009. Individual #538 had diabetes mellitus, seizure disorder, osteoporosis, and chronic constipation. • The core vaccinations were administered. There was no documentation of immunity to varicella. • The Annual Medical Summary did not document the history of cervical dysplasia. This history was important in terms of establishing the risk level that determined the frequency of cervical cancer screening frequency. • Breast cancer screening was current. • Fecal occult blood testing was completed and was negative. Colonoscopy had not been completed. • The individual was not on the colonoscopy list or osteoporosis list. • The date of onset or diagnosis of diabetes was not documented. The individual did not receive any reno-protective agents, such as ACE inhibitors or ARBs. There was no documentation of urine microalbumin or urine protein/creatine ratio in the labs and there was no sensory exam or documentation of why one was not done. • The Annual Medical Summary (3/7/11) contained outdated information. The last BMD was listed as 2005. A more recent BMD was completed in 2010 and showed osteoporosis. The BMD was considered extremely low for age and the recommendation was to look for secondary causes of bone loss. There was no documentation of this recommendation in the IPN. The individual received calcium and Vitamin D supplementation. Treatment with Reclast was recently administered. Vitamin D levels were monitored. • A Quarterly Medical Summary, dated 8/19/11, was present in the records. The summary did not note that the individual's current osteoporosis management. **Do Not Resuscitate** The monitoring team requested a list of individuals with current DNR orders as well as the reason for the DNR orders. Individual #515 had a diagnosis of CHF and pneumonia. Age and declining status resulted in the DNR. The medical director stated the facility followed the guidelines provided in the state issued draft policy. **Seizure Management** Progress was made with regards to the provision of neurological services and seizure management. A database was established to track key information for individuals with	

#	Provision	Assessment of Status	Compliance
		seizure disorders. These individuals received care in the neurology clinic of an academic medical facility. Overall, this service appeared to be of great value to the individuals as management was comprehensive. There was no effective means of achieving the appropriate neuropsychiatric consultation. Scan calls were occasionally conducted with the physician assistant from the neurology department of Scott and White Medical Center. A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 103 individuals with a diagnosis of seizure disorder. With regards to drug use: • 56 of 103 (54%) individuals received 1 AED • 31 of 103 (30%) individuals received 2 AEDs • 10 of 103 (10%) individuals received 3 AED • 6 of 103 (6%) individuals received 4 AEDs • 0 of 103 (0%) of individuals received 5 AEDs • 40 of 103 (39%) individuals received at least one older drug, such as Pb, mysoline, and dilantin The clinic records of these individuals were reviewed. All of the individuals had been seen within the previous year. The clinic notes documented data, such as drug dosages, type of seizure activity, number of seizures, drug side effects, and lab results. Physical findings were documented and recommendations provided. Overall, the notes reflected appropriate care and consideration of key issues related to seizure management. The monitoring team did, however, find issues related to the transfer of information and follow-up. Several of the notes documented the staff's report of side effects and it was good to have a familiar worker relay this information. The data contained in the MOSES evaluation would assist the neurologist in tracking side effects. A few examples of clinic notes are below. • Individual #587: 2/25/11 –Individual was seen in clinic for routine follow-up and was doing well. No seizures had been documented since 1989. Pertinent labs and diagnostics were reviewed. The recommendations were made to obtain a follow-up CT scan of the head in 2012 and continue medication for life due to the diagnosis of tuberous sclerosis. • Individual #338: 4/5/11 – The individual was seen for routine follow-up of seizure disorder and headaches. There was no recent seizure activity. Staff reported headaches appeared better. The review of systems, past medical history, and medication records were reviewed. The neurologist documented that the medication changes recommend at the previous visit in 2007 did not appear to have been made. The recommendation was to decrease Keppra and increase Topamax due to behavioral issues and headaches. The	

#	Provision	Assessment of Status	Compliance
		recommendation was made again. o This case illustrates a possible lack of follow-up. Due to the implications of behavioral issues, it also highlighted the need for neurology–psychiatry consultations. • Individual #40: 4/1/11- Individual was seen in clinic for six month follow-up. Since the last clinic visit, the individual was involved in an altercation, sustained head trauma, and developed a subdural hematoma. There did not appear to be any increase in seizure activity following this event. The clinic note documented the history, review of systems, past history, medications, and physical exam. It was documented that no lab results were sent with the individual. The recommendation was for close observation and follow-up in six months with all appropriate data. The facility revised its seizure management policy. This policy focused on management of the individuals during and after a seizure. The facility had not developed a comprehensive seizure management policy or clinical guidelines and this should be done. Clinical guidelines should provide guidance on the management of seizure disorders. The goal is to optimize seizure control with the fewest medications possible and minimize side effects. Such management promotes an improvement in the quality of life for individuals with seizure disorders. The Health Care Guidelines provided a comprehensive set of guidelines related to seizure management. The facility should develop a local policy based on these guidelines. In order to provide additional guidance to the medical staff, information on osteoporosis prophylaxis, and laboratory monitoring could be included. The MOSES evaluation should also be considered a part of the transfer packet for neurology clinic appointments.	
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> Two external reviews were completed since the last onsite review. Each review was conducted by a team comprised of a physician and advanced practice registered nurse from other SSLCs. During the conduct of each review, a five percent sample of records was examined for compliance with 32 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were seven essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In order to obtain an acceptable rating, essential items were required, in addition to receiving a score of 80% on nonessential items. The average compliance ratings for essential and nonessential elements, respectively, were 71% and 80% for the second audit. The third audit resulted in compliance rates of	Noncompliance

#	Provision	Assessment of Status	Compliance
		77% ad 85%. The following areas were problematic and failed to achieve 80% compliance rates in both the second and third audits: • Updating of the active problem list • Provision of preventive services and screenings • Documentation of diagnostics in the integrated progress notes • Documentation of consult recommendations in the integrated progress notes • Provision of all appropriate immunizations The QA department generated provider-specific data as well as facility aggregate data. This information was shared with the providers and corrective action plans were generated. Follow-up on corrective action plans was completed by the QA nurse. This provision item addresses the issue completing a review that eventually facilitates the quality of medical care and performance improvement. Assessing the quality of care requires that processes and outcomes be evaluated. In its current format, the review excluded outcome indicators. In order to achieve compliance with this provision item, the facility will need to add components to the review that address outcomes. Selecting clinical outcome indicators based on the state-issued clinical guidelines would be an appropriate starting point, since these are the high priority issues targeted by the state. <u>Mortality Reviews</u> There were no deaths at the facility since the last onsite review. The monitoring team met with the medical director, chief nurse executive, QA nurse, and representative from state office to discuss the mortality review process and follow-up on corrective actions from previous reviews. The QA nurse was responsible for following up on corrective actions. The facility still did not have a formal mechanism in place for oversight of the follow-up. It appeared, however, that some level of follow-up was occurring.	
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;	The facility's QA Policy required that all MSSLC departments implement quality assurance processes consistent with generally acceptable professional standards of care. The medical department had not implemented a formal medical quality program, nor did it develop any policy or procedures related to the process. Notwithstanding the absence of a formal quality program, there were many opportunities to assess the quality of medical services. Internal and external audits were completed, but those targeted processes, such as completion of annual medical summaries and documentation in progress notes.	Noncompliance

#	Provision	Assessment of Status	Compliance
	identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	A medical quality program requires a robust mix of the appropriate process and outcome indicators. The facility developed databases to monitor preventive services, but there was no indication that the information was used to improve quality. Moreover, there were several instances in which the data were inconsistent and, in the case of the osteoporosis data, grossly inaccurate. Data were collected on several outcomes, such as pneumonias and UTIs, but there was no evidence that the data were analyzed, trends determined, and actions taken based on the results. Generally, the staff did not appear to have a clear understanding of the process of quality improvement and often expressed that data were collected for the monitoring team. The facility will need clinical guidelines and utilize those to develop a comprehensive set of clinical indicators. Moreover, the facility will need to ensure that staff receives the appropriate training in data management and that more attention is given to collecting and reporting data accurately.	
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.	The medical department had not drafted any clinical guidelines since the last review. The medical director reported that state office had not issued any approved clinical guidelines. The medical department developed a medical services policy based on state-issued policy.	Noncompliance

Recommendations:

1. The facility must address the issue of medical staffing. If the use of rotating physicians is unavoidable, the facility must take additional measures to ensure some reasonable element of continuity of care. Hiring more physician extenders to work with, not replace, the physicians may provide greater continuity of care (L1).

2. Clinical guidelines for the provision of care must be developed. This is particularly important to ensure that physicians who may be unfamiliar with some of the special supports required have adequate guidance (L1).

3. The format of the Annual Medical Summary should be revised. Consider should be given to the items outlined in Section L1 (L1).

4. The template for the post-hospital summary needs revision to include an area for date and signature (L1).

5. IPNs: ensure done in SOAP format, and legible (L1).

6. Physician orders should include monitoring parameters (L1).

7. The preventive care guidelines should be implemented (L1).

8. The entire content of the lab and preventive care matrix should be reviewed for accuracy. The recommendations within that document should be the consistent with recommendations contained in other policies and procedures (L1).

9. The preventive care database should be expanded to include tracking of cervical cancer screening and prostate cancer screening (L1).

10. The medical director should review the current database to determine why individuals have been excluded (L1).

11. The osteoporosis data should be immediately corrected. The administration of Reclast must be captured (L1).

12. The facility is in need of numerous guidelines for clinical management including osteoporosis, diabetes mellitus, and seizure management (L1, L4).

13. The medical director should review the AED polypharmacy to determine if there is adequate justification for the continued use of the older more toxic drugs (L1).

14. The MOSES evaluation tool should be included in transfer packet (L1).

15. The external audit tool should be revised to include a mix of process and outcome indicators (L2).

16. A procedure should be formalized to follow-up on mortality recommendations (L2).

17. An improved tracking system for labs and diagnostics is needed (L2, L3).

18. Address the issues listed in the case reviews, and determine if these are system-wide issues or if they are only specific to that individual (L1, L2, L3).

19. Creation and implementation of a thorough medical quality improvement program; consider inclusion of the data already being collected by the medical department (L3).

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 Emergency CPR Committee Meeting Minutes – 9/9/11 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 PETII Meeting Minutes (past six months) o Campus RNs Schedule and Attendance Log (7/1-9/23/11)

	o 2011 Campus RN Emergency Records (7/1-9/23/11) o Martin Unit Committee Meeting Minutes (6/24/11) and Follow-up from Committee Meeting o Records of: • Individual #96, Individual #533, Individual #120, Individual #494, Individual #94, Individual #540, Individual #99, Individual #373, Individual #554, Individual #360, Individual #477, Individual #524, Individual #257, Individual #293, Individual #518, Individual #197, Individual #304, Individual #272, Individual #588, Individual #483, Individual #88, Individual #40, Individual #151, Individual #502, Individual #172, Individual #207, Individual #515, Individual #117, Individual #427, Individual #211, and Individual #389 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Norris Buchmeyer o Nursing Operations Officer/Acting Infection Control Nurse, Mary Jane Cotton o Quality Assurance Nurse, Karen Wilson o Hospital Liaison, Rosemary Roberts o Nurse Educator, Paulette Caldwell o Assistant Nurse Educator, Shelly Fedro o Nurse Compliance Monitor, Gabby Brewer o Wound Care Nurse, Dawn Price o Nurse Manager, Whiterock, Lyn Coleman o Director of Continuing Training & Development, Debrah Burgess o Interim Director of the Pharmacy, Ricarda Price-Burke o Campus RN, Kim Kaminski o Campus RN, Pat Carroll o Director of Habilitation Therapy, Brandie Howell o Respiratory Therapist, Marsha Taylor o Interim Nurse Manager, Barnett – Lisa Brown o Nurse Manager, Shamrock – Amy Isabell o Infection Control Committee Meeting – 9/19/11 o Skin Integrity Committee Meeting – 9/19/11 o Clinical Services Meeting – 9/20/11 o RN Specialty Meeting – 9/20/11 o Medication Error Committee Meeting – 9/21/11 o Risk Assessment Training Meeting – 9/21/11 <u>Observations Conducted</u>: o Medication Administration (Martin 1, Martin 2, Martin 5, Martin 7, Martin 8, Barnett 3, Central 7) o Enteral Feeding (Martin 5) o Enteral Administration of Medications (Martin 5, Martin 7, Martin 8) o Dressing Change (Martin 5)

	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. It was updated on 9/8/11 and separated into two sections. The first section consisted of lists of discrete events, usually meetings, trainings, and policy revisions, which had occurred over the past year. It was left to the reader to assume what, if any, effect the event/activity had on promoting progress toward achievement of the provisions of the Settlement Agreement. The second section, however, referenced some specific actions that were expected to help the Nursing Department achieve the provisions of Section M of the Settlement Agreement. The action steps were assigned a responsible person(s), time frames were allotted for completion, and evidence of compliance was specified. This version of the POI was an improvement from the former POI. According to the Chief Nurse Executive and Center Lead for Section M, at the time of the updated POI, the completion status of all action steps were either "completed" or "in process/progress," and the facility's self-rating indicated that it was in noncompliance with all provisions of Section M. The monitoring team was in agreement with these self-ratings. But, notably, the current review revealed evidence of substantial compliance in several actions steps related to some components of assessment and reporting protocols, integration of clinical services, and medication administration. During the onsite review, the presentation book was not reviewed because it was reported that it contained no more information than what was already submitted vis a vis the monitoring team's document request and what was already reviewed by the monitoring team in preparation for the visit.
	Summary of Monitor's Assessment: MSSLC was making progress toward meeting many of the provisions of Section M. During the review, it was consistently noted and observed that the members of the Specialty Nurse team and the Quality Assurance Nurse were an experienced, dedicated, and hard-working group of nurses. Since the prior monitoring review, the Nursing Department had undergone additional positive changes in staff members who occupied positions of leadership within the Department. They continued to demonstrate, by all observations, that they were indeed 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. During the conduct of this onsite monitoring review, 25 individuals' homes were visited and 31 individuals' records were reviewed. Daily examples of opportunities for nurses' engagement and collaboration with other clinical professionals were observed. On a couple of these occasions, nurses stepped up and stepped forward to help guide and direct the delivery of health care supports and services to the individuals. There was also evidence that new systems were being developed and implemented and existing systems were being improved to help ensure that individuals' health needs and risks and the changes in their health status would be more promptly identified and addressed.

	Notwithstanding these positive and notable findings, there was much work to be done, especially since some valuable time and momentum were lost during MSSLC's months of transition and change in leadership. And, despite MSSLC's efforts to provide training, re-training, monitoring, and monitoring the monitors, there were many occasions when nurses, as well as direct care staff members, failed to properly implement planned interventions, policies, and procedures to ensure individuals health and safety. For example, the review revealed problems with nurses who failed to respond appropriately to ensure adequate follow-up for individuals who had suffered injury and showed signs and symptoms of possible infection and/or illness. There were episodes of improper nursing practice that included nurses who failed to follow proper procedure during enteral feeding, which put individuals at risk of aspiration; nurses who failed to properly perform wound/skin care, which put individuals at risk of infection; and nurses who failed to safely administer medications, which put a number of individuals at risk of harm.

#	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.	MSSLC was making progress towards meeting this provision item. For example, according to the POI, MSSLC planned to utilize its previously established "Campus RN Log" to track health care problems and implement unit-based "Weekly Focus Meetings" to help ensure that its nurses would consistently identify, document, report, and follow-up on individuals' emergent health care problems and changes in health status. A review of the Campus RN Log for the period of 7/1/11-9/21/11 revealed that, on a daily basis, the Campus RNs recorded anywhere from 2 to 34 episodes of injury, illness, hospitalization/emergency room, alleged abuse/neglect/mistreatment, suicide threat, etc., which were reported to them from across the campus. The logs noted the time that the Campus RN saw the individual, whether or not an injury report was completed, and the name of the doctor that was notified. The logs also referenced that the Campus RNs referred a number of individuals for follow-up to sick call and/or to their unit RN and/or LVN. Thus, it was clear that the logs were indeed evidence that many health problems were identified and reported on a daily basis. At the time of the review, Weekly Focus Meetings were scheduled to occur across all units at the facility. The monitoring team attended one of these meetings, which was held on the Martin Unit. The meeting was organized and chaired by the unit's Nurse Manager and discussion of focus problems occurred in accordance with an agenda, which referenced a unit-based review of problems, such as medication errors, documentation in SOAP format, care plan responsibilities, infection control related to use/misuse of gloves, and the status of individuals with alterations in skin integrity. Thus, it was clear that at least weekly, the clinical professionals were informed, in general, of health care problems on their unit(s), and, specifically, of particular individuals on their unit with alteration in their skin integrity.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Although it was evident that both the Campus RN Log and the Weekly Focus Meetings were positive steps that MSSLC had taken to improve the timeliness of identification and reporting of significant changes in individuals' health, a rating of noncompliance was made because a review of a sample of individuals revealed that there were frequent and regular absences of performing complete assessments, implementing planned interventions, conducting appropriate follow-up, and keeping appropriate records to address the significant changes in individuals' health status and needs from identification to resolution. During the conduct of this onsite monitoring review, 25 individuals' homes were visited and 31 individuals' records were reviewed. The facility should be commended for maintaining well organized records in a unified record-keeping system with master records and individual notebooks. Nurses' notes were usually in the SOAP (Subjective and Objective (data), Analysis, and Plan) format, but there were a number of occasions when errors and/or incorrect entries, especially date/time of entry, were written over and not properly designated as an erroneous entry. Also, there were several records where nurses and other clinical professionals documented progress notes out of chronological order and/or on the margins of the pages, versus starting at the top of another page of the IPNs. This resulted in a number of illegible entries. The Nursing Department's POI referenced that several "training sessions" were conducted in an effort to improve the facility's nurses' documentation of progress notes, assessments, and care plans. The review of 31 individuals' records, however, revealed that over half of the records included cryptic, uninformative, and incomplete assessments and evaluations of individuals' health needs and risks. For example: • Re: Individual #360's skin integrity – "Not as many pimples as at 9/12/11." • Re: Individual #304's cognitive status and functioning – "She is not aware of herself or environment due to her being blind and deaf." • Re: Individual #524's and Individual #554's meal/intake monitoring – "Tolerated > 50% of meal…done well this quarter," and "No problems noted," respectively. It was reported to the monitoring team that since the prior review, the protocol for ensuring timely nursing assessment, identification, notification, intervention, and documentation of significant changes in individuals' health care status was revised and, currently, any nurse, LVN or RN, case manager or charge nurse, could refer an individual to "sick call," with or without an RN assessment. Notwithstanding this revision, across the sample individuals reviewed, direct care staff members continued to be the most frequently noted initial reporters of health care problems. Also as noted in prior reviews, the direct care staff members usually reported their concerns to the LVNs. Thus, there	

#	Provision	Assessment of Status	Compliance
		continued to be reliance upon the LVNs to promptly respond to the direct care staff member's report, review the individual and situation, and report their findings to the physician and/or RN for assessment, planning, and monitoring. Thus, although MSSLC changed its process, such that any nurse could refer an individual to sick call, it still fell mostly to the LVN to promptly respond, review, and report. As evidenced by the Campus RN Log, on a daily basis, there were indeed a number of individuals with health care problems that were reported to RNs/physicians. However, in order meet the provision of M1, in addition to reporting, there must also be evidence of adequate and appropriate assessment, intervention, and monitoring to ensure that identified changes in status were addressed. Across the sample records reviewed, breakdowns in this process continued to have both an actual and potential risk of negative outcomes for individuals. For example, on 7/18/11, Individual #304's direct care staff member documented, "…behind [Individual #304's] left knee she has a sore that is open [and] when I removed her Ted Hose it had blood stains. Notified Nurse and Charge." Notwithstanding the direct care staff member's observation and report, there was no evidence of an assessment of Individual #304's wound by her nurse until over 48 hours later when her nurse noted that she had an open wound behind her left knee. On the basis of Individual #304's nurses' assessment, she was referred to sick call. Of note, Individual #304 suffered a Stage III decubitus ulcer behind her left knee. A review of 31 sample individuals' records 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: • On 5/2/11, Individual #257's physician ordered her transfer to the hospital via ambulance for treatment of intractable abdominal pain and hypotension after her gastrostomy tube was changed by her nurse. Notably, for several days prior to this emergent event, Individual #257's nurses' noted frequent episodes of vomiting and complaints by Individual #257 of "hurting." Notwithstanding these significant health problems, Individual #257's nurses failed to document complete assessments and failed to report these significant changes to Individual #257's physician, who documented that prior to 5/2/11, he/she, "…was not contacted verbally or any other way [by Individual #257's nurses]." Of note, once hospitalized, Individual #257 underwent an exploratory laparoscopy, and she was diagnosed with a gastric perforation status-post traumatic removal of her gastrostomy tube.	

#	Provision	Assessment of Status	Compliance
		• Individual #373 was a 17-year-old man who on 7/15/11 at 11:10 pm had alleged oral sexual contact with a male peer. According to Individual #373's record, his direct care staff members walked in on Individual #373 and a male peer in the front day room. It was reported that "[Individual #373's] head was down on [male peer] and [male peer's] pants were down below his waist. Although Individual #373 clearly suffered actual and potential health risks related to his alleged conduct, the RN on the scene failed to document that he/she conducted a complete assessment and failed to develop a plan to ensure Individual #373's health and safety. Rather, he/she noted a "normal assessment" and planned, "No action taken." In addition, in light of Individual #373's conduct and heath risk for sexually transmitted disease, his physician ordered that he should receive an HPV (human papillomavirus) vaccination once consent was obtained/signed. As of the review, there was no evidence of follow-up to this order. • Individual #427 suffered several chronic health problems that included constipation and risk of recurrent urinary tract infection. During the past year, Individual #427 was hospitalized for treatment of a urinary tract infection with septicemia. A review of Individual #427's record revealed that on a number of occasions, his nurses noted that he failed to move his bowels in three (or more) days. Although Individual #427's nurses administered Dulcolax suppositories to address his constipation, they frequently failed to conduct follow-up to ensure that Individual #427 actually moved his bowels as a result of the suppositories. In addition, despite his history of infection with septicemia, on more than one occasion his nurses noted that he "felt warm," "sounded rattley (sic)," was "running a fever," etc., and, when obtained, noted that his temperature was greater than 100.0. Despite these changes in Individual #427's health status, his nurses failed to obtain complete sets of vital signs and/or perform complete assessments of his condition. Also, although his nurses administered Tylenol 650 mg and instructed Individual #427's direct care staff members to report changes in his behavior and "feeling of warmth (sic)," his nurses failed to conduct timely follow-up assessments or adequate monitoring of the changes in his health status. • On 6/22/11, Individual #207 was seen by his physician for complaints of burning on urination and white urethral discharge. During the examination, Individual #207's physician noted that he also had lower back pain. Individual #207's physician prescribed antibiotic for seven days and tests for sexually transmitted disease. Although Individual #207's nurse "noted and transcribed" his physician's orders and were obviously aware of Individual #207's diagnosed infection and risk of disease, there was no evidence of an initial follow-up assessment by his nurses until two days later (6/24/11) and no evidence of at	

#	Provision	Assessment of Status	Compliance
		least daily monitoring until resolution of the infection and test results. • During the three-day period of 7/26/11-7/29/11, Individual #94 suffered an ear infection that was positive for e. coli, contusion around his left eye and face, vomiting and diarrhea, fall, and <u>two</u> emergency transfers to the hospital. Notwithstanding Individual #94's health problems and risks, there was no evidence that he was completely assessed and closely monitored after his returns from the emergency room and no evidence that all of his health care issues, which were identified in the integrated progress notes, had follow-up documentation reflecting status of the problem, actions taken, and the response to treatment at least once per day until the problem was resolved. <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 392 Medical Emergency Drill Checklists for April 2011 through July 2011 revealed a significant improvement in the nature and conduct of the drills over the past six months. The overwhelming majority of the drills indicated that direct care staff members responded in a timely and appropriate manner. In addition, in the few instances when there were problems with staff members' response and/or failure to respond to the drills, the problems were immediately identified and addressed. Notwithstanding these positive findings, there continued to be several areas that required improvement. For example, less than 10 percent of the drills referenced participation by nurses and other clinical professionals. Thus, the assessment of the response of the "first nurse on the scene," was almost always marked "N/A." As a result, the testing of EMS activation and presence of emergency medical equipment, such as AED, backboard, bag-valve mask (Ambu bag), oxygen, and suction machine, were also marked "N/A." According to both the former and current state policies governing emergency response, all staff members who provide direct services to individuals must receive emergency response training, and they must demonstrate competence in emergency response. 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 the problems with the presence and participation of nurses in medical emergency drills. The monitoring team immediately reported these findings and shared its concerns with the Director of Competency Training and Development.	

#	Provision	Assessment of Status	Compliance
		During an interview with the Director of Competency Training and Development, it was reported that MSSLC was current in the process of ordering emergency medical equipment and supplies, obtaining clarification of the Emergency Response policy and procedures, and planning re-training for all Drill Instructors in order to meet the expectations of the State's 9/7/11 Emergency Response policy and procedures.	
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.	According to this provision item of the Settlement Agreement, nurses are responsible to perform and document assessments that evaluate the individual's health status sufficient to identify all of the individual's health care problems, needs, and risks. The Settlement Agreement, as well as the DADS Nursing Services Policy and Procedures, affirmed that nursing staff would assess acute and chronic health problems and would complete comprehensive assessments upon admission, quarterly, annually, and as indicated by the individual's health status. Properly completed, the standardized comprehensive nursing assessment forms in use at MSSLC would reference the collection, recording, and analysis of a complete set of health information that would lead to the identification of all actual and potential health problems, and to the formulation of a complete list of nursing diagnoses/problems for the individual. Current annual and/or quarterly nursing assessments were not present in two of the 31 records reviewed. Of the 31 records reviewed, all 29 of the nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including but not limited to medications and treatments, to achieve desired health outcomes. Thus, the conclusions (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. As a result, a rating of noncompliance has been given to this provision item. As noted during all prior monitoring reviews, 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 all prior monitoring reviews, at MSSLC, IPNs were episode-driven (i.e., they were notes written in response to narrow, specific, and significant changes). Thus, across the 31 sample individuals reviewed, records failed to reveal individuals' progress toward achieving the functional outcomes/service objectives of their health care plan goals and failed to provide adequate progress information necessary for the staff members to work with the individuals.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Also at MSSLC, in addition to the annual and quarterly comprehensive nursing assessments, nurses were required to complete a four-page Nursing Admission Summary of individuals who were admitted to the facility and, when applicable, upon discharge from the hospital and readmission to the facility. Since the prior review, there was significant improvement noted in the nurses' completion of these forms. Of the 31 records reviewed, 16 were records of individuals who were transferred to the emergency room and/or hospitalized during the period of 3/1/11 – 9/22/11. Almost half of the 16 individuals' Nursing Admission Summaries were complete. But, the incomplete summaries tended to have one or more pages missing and important sections pertaining to communicating the individuals' special needs to direct care staff members, initiating NCPs/MCPs for specified problems, and conducting nurse to nurse reports that were left blank. Other examples are given below: <u>Regarding specific individuals</u> • Individual #293 had many physical and psychosocial health needs and risks. For example, he was diagnosed with profound mental retardation, impulse control disorder, urethral stricture, blindness, gastritis, dysphagia, hypercholesterolemia, etc. He was required to wear bilateral hand mittens to prevent injury and/or removal of his suprapubic catheter, and noted to be nonverbal and non-ambulatory. According to Individual #293's physician, he suffered chronic urinary tract infections and recurrent skin infections that were positive for MRSA. Over the past six months, Individual #293 was hospitalized for urinary tract infection, pneumonia, aspiration pneumonia with MRSA septicemia. Notwithstanding these significant health problems, needs, and risks, Individual #293's quarterly nursing assessment failed to reference an evaluation of his medications and treatments, his tolerance of his enteral nutrition, his neurological and musculoskeletal systems, his ears/eyes/nose/throat, and his oral hygiene. In addition, although it was noted in the assessment that Individual #293 had suffered an "unplanned weight gain," it failed to evaluate the impact of his 30-pound weight gain on his health needs and risks. Also, Individual #293's nursing assessment inaccurately portrayed his hospitalization for treatment of bronchitis and urosepsis as simply "outpatient" treatment for "bronchitis." • Individual #554 was a 14-year-old boy, who was newly admitted to MSSLC. Despite the presence of his mother during his nurse's admission assessment, there was no evidence that his nurse made attempts to obtain relevant, important health information and history from his mother. For example, there was no information regarding Individual #554's current weight and weight	

#	Provision	Assessment of Status	Compliance
		history, PPD results, sleep history, and/or other relevant aspects of his health history. Also, although Individual #554's most salient health needs during the ensuing quarterly period were his problems associated with blood-lipid levels, thyroid abnormalities, and increased risk of developing diabetes mellitus, his nursing assessment failed to reference one of the single most important consultations conducted during the quarterly period - his pediatric endocrinology consultation and recommendations. As a result, his nurse's assessment failed to conclude with a complete list of Individual #554's nursing diagnoses. • Individual #533 was a 61-year-old man with many health needs and risks. His nursing assessment failed to list all of his current active medical problems, and omitted important health problems such as his peripheral vascular disease, hemorrhoids, and nicotine dependence. In addition, Individual #533's nursing assessments inaccurately portrayed the frequency of his seizures. For example, his 6/22/11 quarterly assessment indicated that the date of his last seizure was 2/20/11, however, during the quarterly period, Individual #533's record indicated that he suffered weekly, if not almost daily, episodes of seizure activity. Also, immediately prior to the completion of Individual #533's nursing assessment, he suffered a fall with a head injury. His physician ordered a CT scan of his head to rule-out a subdural hematoma and donning a helmet during the day to protect his head from further injury. However, his 6/22/11 quarterly assessment indicated that he had "no problems this quarter" related to his head and neck. • Individual #304 was a 62-year-old woman diagnosed with profound mental retardation, cervical myelopathy with quadriparesis, stable communicating hydrocephalus, chronic mild leukopenia, blindness, hearing impairment, seizure disorder, osteoporosis, periodontal disease, stage III decubitus ulcer, and histories of gastritis, stroke, and urinary tract infections. Individual #304's nursing assessments failed to list several of her current active medical diagnoses and peculiarly concluded, "No high [health] risks noted." In addition, despite her problems and risks related to skin integrity, elimination, and mobility, her nursing assessments failed to reference an evaluation of her response to and effectiveness of her medication and treatments, her bowel elimination pattern, her upper extremities, and her upper and lower extremity strength. • Individual #540 was a 48-year-old man who was diagnosed with profound mental retardation, schizophrenia, kyphoscoliosis, constipation, dysphagia, deviated nasal septum and cleft palate, GERD, left ventricular hypertrophy, respiratory disease, hypospadias, hypogonadism, astigmatism, and contracted left thumb. Individual #540's nursing assessment inaccurately reported that he had "no problems" related to his endocrine and genitourinary systems. This	

#	Provision	Assessment of Status	Compliance
		error was and especially critical oversight due to actual and potential health risks Individual #540 may have suffered related to his hypospadias and hypogonadism, such as fatigue, low energy, depression, osteoporosis, urethral stricture, and/or other possible outflow obstructions. In addition, during one of the quarterly periods reviewed, Individual #540 had a full mouth extraction, which was complicated by respiratory distress, blood-oxygen desaturation, and pain. Notwithstanding the actual and potential impact of these health problems on Individual #540's needs and risks, his nursing assessment failed to evaluate these problems and referenced that the reader to "See [the] IPNs." <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, vision and hearing impairments, and psycho-social challenges, including, but not limited to aggressive and/or self-injurious behavior, were either not adequately portrayed by the individuals' nursing assessments and/or not referenced in the individuals' lists of nursing diagnoses. • When significant weight changes were documented, there were no evaluations of the nature and impact of the changes on the individuals' health status. • 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. This was especially relevant for individuals who were overweight and at risk of heart disease and diabetes. • Lists of nursing problems/diagnoses were incomplete and, occasionally, referenced problems/diagnoses that were not identified or revealed during the comprehensive assessment or elsewhere in the individuals' records. • Nursing summaries were confusing. The summaries were usually run-on sentences and/or lists of discrete events, such as medication changes, appointments, lab test results, clinic visits, etc., which failed to provide an organized, thoughtful, recapitulation of the individuals' health status over the quarterly review period and failed to put forward nursing interventions/recommendations to address the individuals' progress/lack of progress toward the achievement of their desired health outcomes. Sometimes they summarized the review period, and other times they referenced events, illnesses, etc. that occurred in the distantly related past. • As noted in the prior review, the Respiratory Therapist (RT) was a member of	

#	Provision	Assessment of Status	Compliance
		the Nursing Department and under the supervision of the CNE. During the conduct of this review, seven of the 31 sample individuals 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 one of the seven individuals was visited by the RT on multiple occasions, four of the seven individuals were visited by the RT on two or less occasions, and two of the seven individuals were not visited by the RT during their extensive post-hospitalization recovery periods. • During the RT's visits to the five individuals, the RT conducted limited respiratory assessments and, despite the differences in individuals' health status, needs, risks, and co-morbid conditions, the RT put forward the same plan of action for all individuals – "Continue to monitor for acute respiratory status changes, continue [treatment regimen], and notify RN/MCP of changes noted." There was no evidence that the RT ensured that the individuals at MSSLC received the benefit of the RT's substantial freedom to evaluate, diagnose, and make recommendations to meet their various needs and risks. In addition, there was no evidence that the Nursing Department had made attempts to ensure that the RT was part of a collaborative process that assessed, planned, implemented, coordinated, monitored, and evaluated the options and services required to meet the individuals' respiratory health needs in a manner characterized by advocacy, communication, and resource management that promoted quality and cost-effective interventions and outcomes.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	According to the Health Care Guidelines and DADS Nursing Services Policy and Procedures, based upon an assessment, a written nursing care plan should be completed, reviewed by the RN on a quarterly basis and as needed, and updated as to ensure that the plan addressed the current health needs of the individual at all times. 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 within a specified timeline of implementation of the interventions. According to the facility's POI, Section M3, since the prior review, the only step taken by the facility to meet the requirements of this provision item was that, on 4/12/11, nursing administration met with the MSSLC nurse managers and told them of their expectations for nurse managers to develop nursing care plans with the direct care staff members "so that instructions are easily understood and implemented." It was unclear from the action step how direct care staff members who were absent or working another shift when the plans were developed would come to understand and implement nursing care plans. In addition, the aforementioned expectation could be realized only when, or if, nurses developed complete, accurate, updated care plans with individualized interventions and	Noncompliance

#	Provision	Assessment of Status	Compliance
		directions for direct care staff members to follow. During the prior review, it was noted that the HMPs/ACPs were in need of substantial improvement in order to meet the provisions of the Settlement Agreement. Since the prior review, the results of the facility's own reviews and monitoring of nursing care plans revealed compliance scores that ranged from 20% to 100% on only very small samples of nursing care plans (varied from sample of five to sample of one). Currently, the monitoring review of 31 individuals' records revealed an overall decline in the presence, nature, and quality of individuals HMPs and ACPs, which were in striking disarray. Some general comments regarding the 31 sample individuals' care plans are below. • Most of the 31 individuals' records plans included a one to two-page plan called a "Functional Outcome: Health Maintenance Plan," but some did not. • The Functional Outcome Health Maintenance Plans usually referenced two to four particular health goals that the individual was expected to achieve over the course of 12 months. The goals that were listed usually corresponded to the individual's current nursing problems/diagnoses list. However, this was problematic since, as noted above, the nursing problems/diagnoses list, which emanated from the comprehensive assessment and evaluation of the individual, were almost always incomplete portrayals of the individual's health problems, needs, and risks. • Almost half of the individuals' records contained only the one to two-page list of goals/outcomes and failed to include any planned interventions, with associated time frames and responsible staff members, to achieve the specified goals. Thus, it was unclear how the individual would be expected to achieve his/her goals absent meaningful plans and strategies to do so. • Individuals' records also contained an assortment of various and overlapping generic, stock, mini-plans with various dates and time frames, some of which were reviewed at least quarterly, most of which were not. • Current plans were mixed with outdated plans that lacked information and/or evidence of resolution/discontinuation, which made it difficult, if not impossible, to discern what interventions the nurses and direct care staff were expected to implement and evaluate. • Thus, not surprising, there were significant discrepancies between the interventions referenced in the plans that were expected to be implemented versus the actual delivery of health services and supports to the individuals. • Although there were a few plans with dates and signatures indicating periodic, albeit not quarterly, reviews of HMPs, changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and	

#	Provision	Assessment of Status	Compliance
		expected outcomes did not trigger or result in revisions to their HMPs and ACPs. • The newly formatted 2011 PSPs failed to include any specific, meaningful recapitulation of the individuals' health status over the past year and, even briefly, failed to describe whether or not they benefitted from the planned healthcare interventions and strategies put forward in their care plans. Rather, the newly formatted PSP section entitled, "Medical/Identification of Health Risks," included only information on the individual diagnoses, prescribed medications/treatments, and his/her PST's determination of his/her low, medium, and high health risks. Information related to the individual's health, wellness, and response to nursing care plans was limited to one or two sentences that simply specified what nursing care plans should be developed/implemented. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #554 was a 14-year-old boy who suffered several health care problems that were not common to boys his age. For example, he was diagnosed with ichthyosis, which is a rare skin disorder characterized by the presence of excessive amounts of dry surface scales that visibly and chronically shed, enuresis, hypertriglyceridemia, and abnormal TSH. In addition, he was at high risk for developing diabetes mellitus. Individual #554 had one health/nursing care plan filed in his record that was entitled, "Effective Therapeutic Regimen." The goal of this plan was for Individual #554 "to maintain an effective therapeutic regimen for the treatment of [all of his Axis I diagnoses], enuresis, and ichthyosis." In addition, there was a parenthetical inserted in the body of the plan that stated, "This [plan] will also cover injury, weight gain/loss, side effects of medications, and any abnormal lab values." Notwithstanding the purported goal of the plan, which was to "cover" all of Individual #554's health problems and needs, the generic interventions put forward in the plan completely failed to adequately address the psychological, emotional, and social impact of Individual #554's health problems. In addition, the plan failed to reference any specific interventions to address his enuresis, such as limiting fluids in the evening, providing a bed alarm, establishing a voiding pattern and toileting schedule, etc., and it completely failed to address his high risk of developing diabetes mellitus. • Individual #117 was a 49-year-old woman with many health needs and risks that included intractable seizure disorder, cerebral palsy with quadriplegia, scoliosis, dysphagia, GERD, chronic anemia secondary to Depakote, and osteopenia. Over the past six months, Individual #117's physician and neurologist noted that her "seizure activity [was] on the rise." Thus, Individual #117 was prescribed additional anti-seizure medication, Lyrica, which carried	

#	Provision	Assessment of Status	Compliance
		with it the potential for many significant side effects and health risks. Despite her high health needs and risks, Individual #117's record failed to include a complete, up-to-date, nursing care plan. Rather, only a one-page Functional Outcome: Health Maintenance Plan, which referenced goals/outcomes related to her risks for aspiration, injury, and medication side effects (incomplete medication regimen), was filed in her record. • Individual #120 was a 70-year-old woman who had several high health risks and was diagnosed with hypothyroidism, supra-ventricular tachycardia, history of squamous cell carcinoma, hyperlipidemia, scoliosis, obesity, osteoporosis, ceruminosis, constipation, periodontal disease, onychomycosis, vision impairment, and fractured right ankle. The IPNs filed in her record described a woman who had frequent episodes of constipation, weight gain that was most likely secondary to fluid retention, lethargy, hospitalization for treatment of pneumonia, and de-conditioned status, especially since her fall and fracture. Notwithstanding her multiple health needs and risks, her record contained only three health management plans related to falls, weight gain, and constipation. Not one of the plans was individualized to meet Individual #120's specific needs, and the constipation plan was incomplete. There were no HMPs developed to meet her many other chronic health needs and no ACP implemented to address her 9/14/11 episode of pneumonia and probable heart failure. • Individual #40 was a 45-year-old man who was diagnosed with seizure disorder, impulse control disorder, enuresis, leukopenia, constipation, pterygium, positive PPD, and periodontal disease. In addition, on 3/12/11, Individual #40 suffered serious injuries – occipital subdural hematoma and right clavicular fracture - after he was body-slammed by a peer. On 9/7/11, he suffered a fall in the shower and sustained compression fractures of multiple vertebrae. Although this type of fracture was known to be very painful and associated with risks of weakness and numbness of his extremities, there were no HMPs and/or ACPs to address his care and treatment needs associated with his fractures including, but not limited to, pain management. • Individual #588 was a 37-year-old man who was diagnosed with cerebral palsy, hypothyroidism, extrapyramidal symptoms (EPS), dysphagia, and blindness. Over the past several months, Individual #588 was hospitalized from 5/22/11-5/31/11 for treatment of pneumonia. On 6/13/11, Individual #588 had a modified barium swallow study that revealed silent aspiration when presented with thin liquids. Individual #588 had an ACP to address his 5/20/11 respiratory illness and two other HMPs – one to address his falls, the other to address his weight gain. Although his 3/7/11 PSP and subsequent PSPAs recommended nursing care plans to address his health needs and risks, at the time of the monitoring review, there were no plans developed to address his	

#	Provision	Assessment of Status	Compliance
		chronic respiratory needs and risks, especially related to aspiration, and no plans to address his chronic health problems, such as dysphagia, hypothyroidism, movement disorder, and alteration in skin integrity.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	Since the prior monitoring visit, the plans and priorities of the Nursing Department with regard to establishing and implementing nursing assessment and reporting protocols at MSSLC were affected by significant changes in leadership. Over the past six months, the facility Director and Assistant Director of Programs retired, and the NOO resigned. However, the acting facility Director, who had been at the facility only a few short months, provided the Nursing Department with direction, guidance, and unfailing support in their efforts to, "work smarter, not harder." The CNE was also instrumental in helping to prevent decline in many areas where nursing assessment and reporting were being developed. Under the leadership of the CNE, and with the support and dedication of the specialty nurses, they collectively worked to keep the Nursing Department moving forward. At the time of the review, the new Nursing Operations Officer, who was not new to the facility, had been on the job only two short months, yet she quickly immersed herself into her new role. Thus, new and positive changes were planned and several were already underway. For example, since the NOO's appointment, she scheduled a mandatory meeting with all nurses to review the expectations of MSSLC and the Settlement Agreement, began conducting time audits, established a database to assist with the tracking and monitoring of nurses' assignments, shifts, schedules, performance issues, etc., and participated in the MSSLC's At-Risk Committee/Team to provide hands-on training and guidance to the PST during the risk assessment process. But, within each area of positive change, there continued to be a substantial amount of work to be done in order to achieve compliance with this provision of the Settlement Agreement. Therefore, this provision 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 Compliance Monitor, and acting 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, several changes in personnel occurred when nursing leadership positions were lost to other departments. 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-	Noncompliance

#	Provision	Assessment of Status	Compliance
		/home-based nursing duties. The CNE reported that, since the prior monitoring review, the members of the Nursing Department had worked hard to address the recommendations put forward in the review report. Thus, it was the opinion of the CNE, that there was progress in all areas of Section M of the Settlement Agreement. Indeed, the review revealed that, of all provisions in Section M, M4 showed the most improvement. For example, during the conduct of the review, the monitoring team observed almost daily opportunities for collaboration and integration among clinical professionals, and observed several direct care nurses step up and step forward to guide and direct the delivery of health care to the individuals. There was also evidence that new systems that were being developed and existing systems that were being improved were helping to ensure that individuals' health needs and risks, as well as the changes in their health would be more promptly identified and addressed. The former Nurse Recruiter, who was still attending job fairs and maintaining a close relationship with Navarro College, was assigned the duties of Nurse Compliance Monitor. As such, it was her responsibility to monitor MSSLC's progress toward compliance with Section M. The Nurse Compliance Monitor dug into this new role on 8/1/11. Since that time, she reviewed nursing care, in accordance with the 12 monitoring tools, and developed a system of identifying problems and barriers to compliance that incorporated the oversight of corrective actions to address and resolve problems and remove barriers to compliance. No small task, but one that was long overdue to ensure the development and implementation of reliable and effective assessment and reporting protocols. One of the goals of the Nurse Compliance Monitor was to improve nurses' documentation of what they do to address the health needs of individuals, which she was prepared to "stay on top of, until it's done." Since the prior monitoring review, the CNE reported that the Hospital Liaison had continued to make improvements in the areas of integration of clinical services and communication between external providers and the facility's Medical Director and physicians. A review of 31 individuals' records revealed that, over the past six months, 11 of the 31 individuals were hospitalized one or more times. A review of these individuals revealed that they all benefitted from the oversight of the Hospital Liaison and her designees, who assisted in carrying out the duties of the Hospital Liaison when she was absent or off-duty. Individuals who were hospitalized at the local hospital were visited daily, others, who were hospitalized at facilities more than two hours from MSSLC, were afforded daily follow-up daily vis a vis telephone. The Hospital Liaison communicated her assessments of individuals' hospital care/treatment and their response to treatment via written reports, which were sent to	

#	Provision	Assessment of Status	Compliance
		the individuals' nurse case managers, physician, and DCS Supervisor, and were also filed in the individuals' records. A review of a number of these reports revealed that they provided the MSSLC clinical professionals a wealth of information relevant to the individuals' status, response to treatment, and needs upon discharge. In addition, the Hospital Liaison ensured that the assessment and reporting of individuals' weight upon return from the hospital was completed. As such, the Hospital Liaison continued to remain directly involved in the daily process of nursing assessment and reporting protocols. Another step taken by the facility to achieve improvement in the assessment component of the nursing process was the continued expansion of initial and on-going training and education of its nurses and direct care staff members. During the monitoring team's interview with the Nurse Educator and Assistant Nurse Educator, the positive response to the facility's five-day, intense "On the Job Training Curriculum" was reported. The facility's Assistant Nurse Educator taught the curriculum, which included training, education, and testing across many areas of nursing practice, over a five-day period. In addition, the Assistant Nurse Educator had developed, with the assistance of the Nurse Educator, a training program for direct care staff members that afforded them training on the "clinical indicators" associated with many of the health problems and needs of the individuals who reside at MSSLC. The Assistance Nurse Educator conducted these training sessions as a part of direct care staff members' annual refresher training course. This was a very ambitious and positive step taken by the Nursing Department to meet the training needs of direct care staff members, who were delegated a number of health care duties. The Nurse Educator provided the monitoring team with the Nursing Education Handbook, which had been revised in accordance with the State's standards and expectations for the training and education of its nurses. In addition, the handbook was supplemented by many interesting articles, website addresses and information, and other education materials and resources for nurses. The Nurse Educator also reported that, "probably next month," MSSLC will get on with the statewide nurse education initiative, which is specifically designed to help improve the capacity of the RN case managers and RN managers in the performance of nursing assessments. This was much anticipated training given the findings, as noted in Section M2, of serious problems in the accuracy and completion of the assessments reviewed. 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	

#	Provision	Assessment of Status	Compliance
		twice a month. During the review, the monitoring team attended a Skin Integrity Committee Meeting. The meeting 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 a recent, significant improvement in the completion of the "Disposition" columns, which were previously blank and without recommendations and/or corrective action plans to address areas of concerns were documented. The Wound Care Nurse, who ensured that when a problem was identified, it was addressed with a plan to correct it. During the monitoring team's interview with the Wound Care Nurse, she reported that the Skin Integrity Policy was finalized, presented to the Nursing Department, and in effect. In addition, the Wound Care Nurse had developed an IPN form/format for the documentation of an assessment of individual's skin integrity, which was also in effect. Another action step taken by the Wound Care Nurse to improve compliance with assessment and reporting protocols sufficient to address the health status of the individuals served was that she regularly attended the unit-based Weekly Focus Meetings and brought with her the wound care tracking/trending data, which she used to inform direct care staff members, nurses, and other clinical professionals about the skin care needs of the individuals who resided on the units. Notwithstanding these positive findings, the protocols to address non-healing wounds and the monitoring tool to address compliance with positioning/re-positioning plans, which were recommended by the Skin Integrity Committee in May 2011, had not been developed or addressed by the Health Services Committee, as recommended. Since the prior monitoring review, the Infection Control Nurse was appointed to the position of NOO. Since the appointment, the NOO had assumed the responsibilities of both positions. During the review, the monitoring team attended the Infection Control Committee meeting. The meeting, which was led by the NOO/Acting Infection Control Nurse, was very well organized and attended. The agenda topics referenced all relevant areas of monitoring and surveillance of actual and potential risk of infection, and the presentation and discussion covered topics, such as air purification on the Martin unit, suction toothbrush pilot project, vaccination updates, review of infection tracking and trending data, etc. As noted in the prior report, it was apparent that the NOO/Acting Infection Control Nurse had 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 NOO/Acting Infection Control Nurse continued to be present, able, and willing to provide advice, training, and onsite mentoring for all employees and individuals.	

#	Provision	Assessment of Status	Compliance
		During the Monitoring team's interview with the Infection Control Nurse, she gave numerous examples of ways in which MSSLC had continued to progress toward the goal of "preventing infectious processes and providing teaching to employees and individuals." For example, special virucidal products were researched and purchased, two-step TB skin tests continued to be performed, new touch-less, non-alcohol based dispensers were placed on the Whiterock, Longhorn, and Shamrock units, the TSICP annual convention was attended, and, effective 9/1/11, a "Minor Care Clinic" was opened to employees for treatment of minor on-the-job injuries, such as small cuts, scratches, and bite wounds. With the help of an assistant, the NOO/Acting Infection Control Nurse continued to review sick call sheets/logs, read 24-hour reports, contacted home managers, and conducted "spot checks." They also continued to receive information from the facility's physicians and pharmacy related to antibiotic prescriptions and practices across the facility. All of the information related to identification, tracking and trending, and reporting of infections were maintained in a database and presented to the facility's Infection Control Committee during their monthly meetings. Since the prior monitoring review, the NOO/ Acting Infection Control Nurse continued to conduct research and publish articles about important and relevant aspects of infection control and prevention in the facility's employee newsletter. For example, in the Summer issues of the employee newsletter, she published an article entitled, "The Zanfel Zone: Your Information Resource for Poison Ivy, Oak, and Sumac." In the area of infection prevention and management, the question of how the NOO/Acting Infection Control Nurse would be able to continue to keep up with the demands of both positions, since each one was equally consuming of time, attention, and much hard work, loomed large. This question was especially relevant since one of the most disturbing observations made by the monitoring team was the conduct of several nurses who failed to observe basic infection prevention and management strategies and put individuals at needless risk of infection and illness. 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 attended most, if not all, clinical committee meetings, conducted monitoring of all aspects of nursing care, carefully and thoughtfully reviewed incidents, injuries, and deaths, and, most importantly, ensured that the outcomes of her reviews were relevant and helpful to meeting the provisions of the Settlement Agreement. Of note, since the prior monitoring review, there were no deaths at the facility. However,	

#	Provision	Assessment of Status	Compliance
		there was an incident that occurred that resulted in a "Safe Harbor Peer Review," which was the process requested by a nurse under TOC §303.005 to ascertain if the nurse was requested to engage in conduct that would violate the Nurse Practice Act (NPA) or BON rules, or violates the nurse's duty to a patient and to determine the nurse's duty. Thus, the QA Nurse, who was also the Chair of the MSSLC Peer Review Committee, was assigned the responsibility to ensure that the Safe Harbor was properly invoked and implemented. This was no small task for the QA Nurse, who was assigned a job that was not well understood by most administrative leaders and clinical professionals. Nonetheless, the QA Nurse completed the assignment with diligence and professionalism equal to that, which regularly occurred during the performance of her duties to improve the quality of nursing assessment and reporting protocols at MSSLC. There was a plan underway to provide training to the MSSLC nurses on the State's "Safe Harbor Peer Review" policy and procedures.	
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 was nine months into its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the PSP process. According to the facility's POI, since the prior monitoring review, the Habilitation Department provided training in high risk habilitative care issues to the nurses on two units, and three high health risk health problem areas – infections, wounds, and end of life issues – were targeted for specific improvement actions. For example, a new policy and IPN form pertaining to wound care was finalized and presented to the Nursing Department and end of life care planning issues were presented and discussed at the 4/12/11 Nursing Administrative Meeting. One of the most obvious steps taken by the Nursing Department to participate in the development and implementation of a system of assessing and documenting individuals' indicators of risk was the attendance and participation of the individual's nurse in the PST process. During the conduct of the review, the monitoring team attended two PSPA meetings, which were held as a result of significant changes in individuals' health and/or behavior status and needs. Both of the QMRPs who chaired the meetings were prepared, organized, and participated in keeping the meeting discussion focused and on track. Although the QMRPs gave some of that role/responsibility to the individuals' clinical professionals and frequently sought out the physician's guidance and opinions, it did not take away from the process. The conduct of the RN case managers who participated in the PSPAs continued to need improvement. For example, during Individual #293's PSPA, the nurse case manager came to the meeting somewhat prepared, but failed to bring pertinent information and data with him/her to the meeting, did not express the clinical basis for his/her opinions regarding the individual's level of risk for particular areas of his health status, and frequently deferred to others' decisions regarding level of risk. For example, during the	Noncompliance

#	Provision	Assessment of Status	Compliance
		discussion of Individual #293's oral hygiene and ability to manage his oral secretions, it was unclear whether or not the nurse case manager had investigated how his diagnosis of GERD was established and had conducted a recent visit to Individual #293 during his morning hygiene/ADLs in order to obtain first-hand knowledge of his status pertaining to the areas of risk, which were slated for review All 31 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and 19 of the 31 individuals reviewed were referred to as having one or more "high" health risks. Since 1/1/11, approximately three-fourths of the 31 sample individuals whose records were reviewed were also reviewed by their PSTs and assigned levels of risk that ranged from low to high across several health and behavior indicators. As noted in the prior report, there continued to be problems with the assignment of high risk ratings, which, according to several clinical professionals, were not chosen because of the frequency with which the PST was required to meet once an individual was assigned one of more high risk ratings. Also, as noted in the prior report, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. Therefore, this provision item was rated as noncompliance. Examples included the following: • Over the past several months, Individual #427 was hospitalized for treatment of acute bronchitis, urinary tract infection, and septicemia. In addition, he frequently required PRN administrations of Dulcolax suppositories because he failed to move his bowels for three to four days at a time. Nonetheless, Individual #427's risk rating form indicated that he remained at "medium" risk for respiratory compromise because he had only one recent episode of pneumonia, at "medium" risk for constipation and bowel obstruction because he had a "nursing care plan," "received daily medication," and had not yet suffered a bowel obstruction," and at "low" risk for urinary tract infection despite his hospitalization for urinary tract infection with septicemia. • During the two-month period prior to Individual #494's annual staffing and PSP, she suffered seven falls. On many of these occasions, when she fell, she hit her head and/or landed on her buttocks, which increased her risks of head injury and compression fracture. According to Individual #494's 8/10/11 PSP and 7/27/11 annual staffing review, she has "No high risk health issues." In the four weeks after Individual #494's annual staffing review, absent identification and planning to address Individual #494's obvious health risks, she fell at least four more times and suffered repeated injuries to her head, face, and hips. • Over the past several months, Individual #588 was hospitalized with pneumonia, and he demonstrated silent aspiration during his 6/13/11 modified barium swallow study. In addition, his direct care staff members frequently	

#	Provision	Assessment of Status	Compliance
		reported that he ate rapidly and required close supervision. Despite these negative health outcomes and risks, as of the monitoring review, his choking and aspiration risks remained "low." • According to Individual #373's 1/28/11 PSP, he was at low risk for all health and dental related problems. Since that time, Individual #373 suffered infections of his skin, eyes, and ear, engaged in unprotected sexual contact with a male peer, and lost over 5 pounds in a one-month period of time. In addition, although Individual #373's physician ordered him to receive the HPV vaccination series to help protect him against serious health problems, there was no evidence that the order was implemented. Notwithstanding Individual #373's health risks and increased likelihood of unprotected sexual contact, as of the monitoring review, all of his health risks remained low.	
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 continued to improve since the prior monitoring review. As indicated in more detail below, although much work still needed to be done to ensure that medications were administered and accounted for in accordance with generally accepted professional standards of care and the Health Care Guidelines, the facility had taken several steps toward identifying and measuring the nature, severity, and scope of their problems in this area. For example, since the prior monitoring review, the medication areas for three homes were moved to more appropriate spaces that were clean and afforded individuals privacy during medication administration. In addition, nurses who were monitoring medication administration were provided additional training that emphasized unannounced observations and closer scrutiny of the process. This provision item, however, was rated as being in noncompliance because there continued to be serious problems in this area. Observations of medication administration, oral and enteral, were conducted on Martin 1, Martin 2, Martin 5, Martin 7, Martin 8, Barnett 3, and Central 7. During three of the seven observations, nurses failed to administer medications in accordance with standards of practice. For example, during the three deficient medication passes, 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 soiled dressings, dirty washcloths, towels, and adult protective garments; nurses administered medications that were expressly ordered to be given one hour before meals either with meals or within mere seconds of their meal being served; administered enteral feedings and medications into individuals' stomachs with syringes versus administration by gravity; failed to rinse and clean enteral feeding equipment after use and before the equipment was stored in plastic bags/re-used; and initialed that medication(s) was given prior to individuals' receipt of medications(s).	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 needless risk of harm. All of the 31 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 six of the seven medication passes observed by the monitoring team. 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. New carts were ordered and the nature and scope of monitoring the administration and storage of medications changed to include unannounced observations of medication administration. 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. Since the prior monitoring review, however, nurses complained more loudly about the time it took to count and record for every individual the number of pills on hand for each medication present in their bin(s). Thus, the CNE approved a pilot project on the Whiterock unit, which began on 7/1/11. According to the CNE, the nurses on the Whiterock unit adopted a system that was in use at another SSLC, where nurses counted all delivered medications and "bagged" them according to day of the week. The CNE reported that the pilot project was "too new to tell" if it would improve accountability, but preliminary reports from the nurses were positive. As reported by the CNE, this project was one more way to make nurses more accountable and pinpoint areas of breakdown and focus in on problems in performance. Even so, nurses must always look at the medication that they are taking from the drawer, bag, cup, etc., and look at the Medication Administration Record before they administer medication, or else errors will continue to occur. The review of 31 individuals' current MARs for the period of 8/1/11 to 9/22/11 revealed much improvement with omissions and/or discrepancies in the MARs of only 5 of the 31	

#	Provision	Assessment of Status	Compliance
		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 seven-week period. During the week of the onsite review, the monitoring team attended the meeting of the Medication Error Committee, which was chaired by the Medical Director. As noted during the prior review, the committee continued to review reported errors, which were largely due to performance deficits by nurses on the Martin unit who failed to give medications, in accordance with individuals' physicians' orders. Although, month after month, the Medication Error Committee continued report "performance deficit" as the root cause of the problem, the strategies put forward to date to address the problem were not strategically planned, focused, interventions, but general strategies of training, monitoring, and re-training applied across the campus. During a discussion of the data analyses and reporting of medication errors, several additional concerns were raised by the monitoring team members: • The total number of errors was limited to the errors committed by nurses and failed to include errors made by physicians, pharmacist, etc. • The total number of errors was based upon "episodes" of errors, versus occurrences of errors. For example, an error that went undetected and involved several nurses who committed the same error over and over during a period of time was counted and presented to the committee as only one error. • There were no systems in place to reconcile medications that were not in the form of pills, tablets, or capsules. • The data presented to the committee was not validated prior to distribution, thus errors in data entry, analysis, etc. were not identified and corrected. • No unannounced observations of medication administration were conducted during the monthly review period. A review of the prior six months' meeting minutes revealed that the committee failed to identify the above-referenced concerns. They did, however, make several important recommendations, which required follow-up by the Nursing, Medical, and Pharmacy Departments. For example, the committee recommended a review of the state's draft policy pertaining to medication administration, clarification of what constitutes a "dispensing error," requested that State officials follow-up with the WORx software experts to ensure that generic and brand names of medications are printed on the Medication Administration Records, and planned to try to obtain new medication carts with drawers/bin space sufficient to accommodate prescribed medications. Since the prior monitoring review, the Pharmacy and Therapeutics Committee continued	

#	Provision	Assessment of Status	Compliance
		to review the frequency and severity of medication errors. Based upon the data presented to the committee, they recommended that a special workgroup consisting of the Medical Director, pharmacy, nursing administration, and physicians should meet to discuss how the Medication Administration Records should be modified to further clarify the exact amount of medication nurses should administer. As of the monitoring review, the workgroup had not been formed.	

Recommendations:

1. Move swiftly to fill the vacant Infection Control Nurse position with an individual of at least equal experience, knowledge, and training to the former Infection Control Nurse (M4, M5).

2. Clarify and explicitly communicate the expectations for the Respiratory Therapist, and ensure adequate and appropriate supervision to promote compliance with expectations (M3, M4, M5).

3. Consider developing additional strategies to improve the collaboration and cooperation between the Nursing and Habilitation Departments, especially in the domain of PNMT, to improve the coordination of individuals' health care (M3, M4, M5, M6).

4. Continue to ensure that Registered Nurses are visible on the homes in the locale of the individuals and their direct caregivers at different times of the day/evening every single day (M1-M6).

5. Consider ways to improve infection control practices on all units and decrease the over-reliance on hand sanitizer versus actual hand washing with soap and water (M4).

6. Clarify what is expected with regard to the development of comprehensive nursing/health care plans (M3).

7. Consider integrating the Functional Outcome: Health Maintenance Plans with 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 (M3).

8. Develop strategies to ensure that clinical professionals participate in emergency medical drills to both maintain competence and set examples for non-clinical staff members to follow (M1, M4).

9. Ensure that nurses consistently document health care problems and changes in health status, adequately intervene, and appropriately record follow-up to problems once identified (M1).

10. Ensure that nursing assessments are complete and comprehensive (M1, M2, M4, M5).

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 DADS Policy #009.1: Medical Care, 2/16/11 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 POI for Section N o MSSLC Organizational Charts o MSSLC Policy: Pharmacy Services, 1/1/11 o MSSLC Policy and Procedure: Adverse Drug Reaction o MSSLC Lab Procedure Matrix o MSSLC Policy and Procedure: Drug Utilization Evaluations 4/18/11 o Pharmacy and Therapeutics Committee Meeting Minutes, 6/29/11 o Medication Error Review Committee meeting minutes: 4/4/11, 4/25/11, 6/6/11,6/27/11, 8/8/11, 9/1/11, 9/21/11 o PET II Meeting Minutes o Single Patient Interventions and Notes Extracts: March 2011 – August 2011 o Adverse Drug Reactions Quarterly Summary Logs: April 2011 – August 2011 o Pharmacy Review of Physician Orders o Medical Review Committee Summaries: 3/23/11, 3/16/11, 3/30/11, 4/13/11, 4/20/11, 4/27/11, 5/4/11,5/11/11, 5/18/11, 5/25/11, 6/6/11, 6/8/11, 6/15/11, 6/22/11, 6/29/11, 7/6/11, 7/13/11, 7/20/11, 7/27/11, 8/3/11, 8/10/11, 8/17/11, 8/24/11 o Quarterly Drug Regimen Reviews for the following individuals: • Individual #432, Individual #249,Individual #335, Individual #524, Individual #26, Individual #448, Individual #311, Individual #538, Individual #587, Individual #575, Individual #329, Individual #386, Individual #353, Individual #349, Individual #539, Individual #217, Individual #127, Individual #235, Individual #105, Individual #98, Individual #300,Individual #37, Individual #591, Individual #536 Individual #181, Individual #267, Individual #306 o MOSES and DISCUS forms for the following individuals: • Individual #524, Individual #588, Individual #228, Individual #420, Individual #219, Individual #92, Individual #283, Individual #474, Individual #155, Individual #394 Individual #550,Individual #221 Individual #146, Individual #360 Individual #238, Individual #261 Individual #359, Individual #432,Individual #335, Individual #26, Individual #311, Individual #587, individual #473, Individual #67 o Drug Utilization Evaluation Summaries: • Lithium

	• Valproic acid Interviews and Meetings Held: o Ricarda Price-Burke, RPh, Acting Pharmacy Director o Abigail Okeke, PharmD, Clinical Pharmacist o Phillip Rolland, PharmD, Clinical Pharmacist o Anyssa Garza, Pharm.D, Pharmacy Director (in orientation) o Dolores Erfe, MD, Medical Director o Norris Buchmeyer, Chief Nurse Executive o Karen Wilson RN, QA Nurse Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Error Reduction Committee o Polypharmacy Committee meeting o Daily Morning Clinical Meetings o Pharmacy Department
	Facility Self-Assessment: MSSLC submitted its self-assessment, the POI. It was updated 9/ 8/11. The POI did not actually indicate what activities the facility engaged in to conduct the self-assessment. The monitoring team reviewed the presentation book with the acting pharmacy director and two clinical pharmacists. The POI did not indicate how the self-assessment was used in determining the self-rating. The facility rated itself noncompliant for all provisions. The monitoring team found the facility to be in substantial compliance for Provisions N1, N3, and N4 during the March 2011 review. Only N4 remained in substantial compliance for this review. The acting pharmacy director did not provide a response related to the self-assessed rating of noncompliance. A plan was included in the POI that outlined 11 action steps. All action steps pertained to Provision N1. There were no action steps related to Provisions N2 – N8. The facility will need to address all provision items in order to achieve substantial compliance.
	Summary of Monitor's Assessment: In order to determine compliance with this provision, interviews were conducted with the acting pharmacy director, two clinical pharmacists, and the medical director. Several facility meetings relevant to pharmacy services and safe medication practices were attended and provided additional information from the chief nurse executive and quality assurance nurse. Discussions were conducted with the medical staff during

	various formal and informal meetings. Pharmacy policies and procedures, meeting minutes, active integrated records and multiple data sets were reviewed. Pharmacy operations were observed during informal observations of the department. The pharmacy department demonstrated limited progress since the last review. Several areas showed signs of regression. The lack of a stable pharmacy staff was likely a contributing factor in the lack of forward movement. Each of the three monitoring team's compliance visits was completed under the leadership of a different pharmacy director. The current acting director assumed the directorship in mid-April 2011 due to the resignation of the previous acting director. At the time of the onsite visit, the pharmacy department was staffed with an acting pharmacy director, one full time staff clinical pharmacist, one full time contract clinical pharmacist, and one fulltime pharmacist. Three fulltime technicians worked in the pharmacy. A new pharmacy director was hired and was participating in pre-service training during the time of the onsite review. The newly hired director received her pharmacy doctorate in May 2011. Documentation of communication between pharmacists and providers continued, but there had been no consolidation of the tracking tools resulting in the use of multiple documents. The number of documented interactions between the pharmacists and medical staff decreased sharply in April 2011, which coincided with the change in pharmacy leadership. The QDRRs were completed, but the quality of the reviews appeared to have diminished since the previous visit. Multiple clinical pharmacists were assigned to these tasks over the past several months, and styles varied considerably. A lab matrix specifying requirements for monitoring was introduced since the last visit. The monitoring of labs associated with the use of Clozaril did not occur as required and this was a particularly troubling finding. Adverse drug reaction reporting increased substantially, but the quality of the data submitted indicated that additional work was needed in this area. The data submitted, potentially alluded to problems with the use of certain classes of drugs, but further analysis will require correction and validation of that data. Drug utilization evaluations were completed and provided good educational information in addition to data on the facility's use of the agents reviewed. Once again, there was no evidence that corrective actions were taken to address the problems noted. Moreover, the connection between the ADR system, DUE evaluations and the QDRRs appeared unrecognized as data from one process never seemed to link to the others. Medication errors remained a serious cause for concern. The monitoring team was also concerned about the reliability of data since there was no validation process in place. Hundreds of medications continued to be returned to the pharmacy. The reliability of the most recent return data was questionable. The facility had yet to implement a means of reconciling liquid medications. Data management issues made it difficult for the monitoring team to determine if any forward movement had occurred in this area.

<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 medication 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. In those cases where the review of the order resulted in questions, the pharmacist contacted the provider for clarification. The facility maintained its process of completing double checks on all pharmacy orders. This process required that two pharmacists review every medication order prior to dispensing from the pharmacy. During previous onsite reviews, the monitoring team viewed evidence of this process because the pharmacy maintained a log of orders processed through the pharmacy showing that verifications were completed. While the process was reported to continue, summary documentation of the process was no longer maintained. Documentation of staff training on the double check process was included in the presentation book.

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 facility actually used several tools to capture communication between the pharmacists and the prescribers, including the Review of Physician Orders (RPO), Single Patient Interventions, and the Notes Extracts.

The Review of Physician Orders (RPO) replaced the Pharmacy Clinical Interventions (PCI) Log in January 2011. The Single Patient Intervention module of WORx was primarily used to document issues related to medication dosing and timing. The Notes Extracts documented a variety of issues, but there was no real explanation on when this was used as opposed to the SPI.

The RPO provided information on the medication involved, the nature of the order problem, and the resolution. The number of RPO entries for the months of March 2011 through July 2011 is presented below.

<table>
<tr><th colspan="2">Pharmacy Clinical Interventions /Review of Physician Orders 2011</th></tr>
<tr><td></td><td>Number of Interventions Reported</td></tr>
<tr><td>January</td><td>70*</td></tr>
<tr><td>February</td><td>56*</td></tr>
<tr><td>March</td><td>59</td></tr>
<tr><td>April</td><td>26</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

May	20
June	15
July	25

*Data for January 2011 and February 2011 were provided during the March 2011 monitoring review.

The types of order problems reported in the log were provided for the months of March 2011 and May 2011 as noted in the following table.

Review of Physician Order Data 2011		
	March 2011	May 2011
Incomplete Orders	32 (54%)	11 (55%)
Order Clarification	1 (2%)	4 (20%)
Possible Drug Interaction	9 (15%)	3 (15%)
Possible Allergy	3 (5%)	1 (5%)
Not Available	6 (10%)	1 (5%)
Duplicate Orders	3 (5%)	--
Other	5 (8%)	--

The most significant issue was related to incomplete physician orders. The medical director provided training in early 2011. The monitoring team inquired about the abrupt change in the number of interactions given the large number of medications dispensed. The acting pharmacy director stated that interactions were recorded. Summary data reporting was not consistent. The quarterly clinical pharmacy report documented 77 interventions for the months April 2011 through June 2011. The Review of Physician Orders log documented 60 interventions for the same time period.

There was evidence that there was discussion of these findings with the medical staff. Documentation of corrective actions was seen in early 2011. Documentation of discussions, however, did not make note of the sharp decrease in the number of reported interventions. This decrease coincided with the change in pharmacy staffing. The acting pharmacy director indicated that documentation occurred as required as best as possible with the current staffing.

Review of Physician Orders Data 2011 Number of Reported Interventions					
	March	April	May	June	July
Pharmacist 1	39	1	1	14	22
Pharmacist 2	20	25	16	1	0

#	Provision	Assessment of Status	Compliance

Clinical Pharmacist 1	--	--	2	0	2
Clinical Pharmacist 2	--	--	--	0	1
Clinical Pharmacist 3	--	--	1	--	--
Total	59	26	20	15	25

The clinical pharmacists recorded few RPO interactions because their role was primarily the completion of retrospective reviews. The data contained in the RPOs warranted further scrutiny relative to the documentation practices of the pharmacists.

A total of 26 interventions were reported in the SPI entries of March 2011 through August 2011. Pharmacist #1 recorded 15 interventions during the two months of July and August, while Pharmacist #2 recorded 11 interventions during the six-month period from March to August.

One hundred thirty pages of notes extracts containing thousands of entries were submitted. The types of notes were categorized into administration, drug interactions, allergy alerts, etc. Based on the enormous number of allergy alerts and potential drug interactions documented, it would appear that medical provider notification might be more evident. It was also noted that there were a few entries by pharmacists into the notes extracts that were not captured in the RPO log.

In the absence of confounders, such as staff leave, it appeared that there was a distinct pattern among pharmacists with regards to documentation of interactions. The pharmacy director should review reporting and documentation patterns and ensure that all pharmacists who participate in the prospective review of physician orders are appropriately documenting the communication with prescribers as required in the Health Care Guidelines.

Finally, this provision item required the review of laboratory testing associated with the use of medications prior to dispensing the medications. The acting pharmacy director stated this was accomplished retrospectively as part of the QDRR, and that a prospective review related to laboratory monitoring was generally not done. She further reported that the pharmacy had access to Avatar, but staff was not familiar with using the system for lab retrieval. In order to achieve substantial compliance with this provision item, the pharmacy will need to have access to laboratory data that is monitored during use of the medications and there will need to be a consensus on the requirements for review prior to dispensing medications.

An important outcome of the lack of a prospective lab review, revolved around the use of clozapine. The clinical pharmacist documented in the June Quarterly Clinical Pharmacy

#	Provision	Assessment of Status	Compliance
		Review that "in several cases we received notification from the clozapine registry that required lab monitoring had not been provided, in one case for 50 days and in several cases for 21 days or longer. This failure to report to the clozapine registry in a timely manner jeopardizes our ability to continue to receive clozapine from our wholesaler." The failure to provide the appropriate laboratory monitoring was a significant problem, because this particular medication should not have been dispensed from the facility's pharmacy without the appropriate laboratory monitoring. The facility planned to complete a clozapine DUE in November 2011. The facility will need to take several actions to achieve substantial compliance with this provision item: • The facility should take appropriate measures to increase the stability of the pharmacy staffing. Processes and systems should be standardized to the greatest extent possible in order to ensure consistency in the work product produced by the various staff. • Given the turnover of staff, it is critical that policies and procedures accurately reflect the processes and systems of the department. All staff should be adequately trained on policy and procedure. • The facility should pursue additional training to ensure that all staff understand the WORx software and its capabilities. • Pharmacy policy should provide guidelines on criteria for use of each documentation tool in order for staff to consistently select the most appropriate form of documentation. • The pharmacy director and medical director should ensure that staff understand the requirements for documentation of interactions between pharmacists and medical providers. Once the expectations are outlined, the process should be monitored and staff held accountable for following the process. The facility will need to implement a system to allow a review of labs and assess the need for labs as part of the prospective review. The use of the Avatar system should be explored.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	During the five months prior to the onsite review, multiple clinical pharmacists completed the QDRRs. The format varied with each pharmacist. There were no reported changes in the procedure. The clinical pharmacists submitted completed DRRs to the medical director's office for distribution to the medical staff who were required 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 medical provider was required to document this in the	Noncompliance

#	Provision	Assessment of Status	Compliance

IPN as well. The documents were returned to the pharmacy following completion. Timelines for provider completion and return were not specified in policy

A sample of 27 QDRRs was reviewed for timelines, pharmacy assessment, and physician response. The table below captures the key dates, drugs, parameters, pharmacy comments/recommendations, and physician responses. The "discussion" represents comments from the monitoring team.

Individual	Key Dates Completion Pharmacy Sign, PCP Sign, Psychiatry Sign	Drugs, Monitoring, Comments/Recommendations
386	6/14/11 6/29/11 7/1/11 7/7/11	• Olanzapine Comments: Continue to monitor FBS, LFT and CMP, BMI and wt Recommendations: Exercise PCP: Agree - dietary counseling Psychiatrist: --* Discussion: The worksheet (WS) noted that BMP/CMP were not obtained appropriately. This was not captured in comments or recommendations. The WS also stated that thyroid testing NA. The lab matrix requires annual testing on all individuals.
539	6/14/11 6/29/11 7/1/11 7/12/11	• Olanzapine, sertraline, desmopressin, ferrous sulfate Comments: Continue to monitor labs, BMI Recommendations: Physical activity to increase HDL; consider reducing dose of olanzapine PCP: Agree - dietary counseling Psychiatrist: Agree - dose decreased
235	6/21/11 6/29/11 6/30/11 7/12/11	• Desmopressin, olanzapine, Concerta, methylphenidate, ferrous sulfate, Comments: Therapeutic duplication; continue to monitor for olanzapine and ferrous sulfate Recommendations: Please consider withdrawing Concerta or methylphenidate PCP: Agree Psychiatrist: Agree – Change to Concerta
536	6/30/11 7/1/11 7/1/11 NA**	• MVI Comments: MVI chew tab Recommendations: None PCP: Agree Psychiatrist: NA
329	6/30/11 6/30/11 7/1/11 NA	• MVI chew tab Comments: None Recommendations: None PCP: Agree Psychiatrist: NA

#	Provision	Assessment of Status				Compliance
		267	6/30/11 6/30/11 7/1/11 NA	• Sodium chloride nasal spray prn Comments: No routine meds Recommendations: None PCP: Agree Psychiatrist: NA		
		37	6/15/11 6/29/11 7/1/11 7/12/11	• Olanzapine, atomoxetine, divalproex Comments: Continue to monitor for side effects of olanzapine Recommendations: Check diphenhydramine dose; exercise; consider changing olanzapine dose PCP: Agree Psychiatrist: Disagree – Needs 15+5 to improve sleep		
		353	6/17/11 6/29/11 7/5/11 7/12/11	• Aripiprazole, metformin Comments: Current wt 311 lbs; FBS 84 WNL, HbA1c 5.7 Recommendations: Adjust metformin dose PCP: Disagree – will recheck FBS and check with PCP Psychiatrist: -- Discussion: The rationale for the recommendation was not stated.		
		127	6/17/11 6/29/11 6/30/11 7/12/11	• Olanzapine Comments: Good glycemic control with olanzapine; wt 265 lbs; CMP - WNL Recommendations: Please consider reducing olanzapine PCP: Agree Psychiatrist: Disagree – clinically indicated Discussion: The rationale for recommendation was not stated.		
		105	6/21/11 6/29/11 6/30/11 7/12/11	• Risperidone, Paroxetine, Atomoxetine, ferrous sulfate Comments: Potential drug interactions between atomoxetine and paroxetine; continue to monitor for risperidone and ferrous sulfate and paroxetine Recommendations: Please consider changing to another antidepressant PCP: Agree Psychiatrist: Agree –Will consider at next quarterly review; this was prescribed by previous psychiatrist; no drug interactions at this time?		
		591	6/21/11 6/29/11 7/1/11 7/12/11	• Ziprasidone, lithium, divalproex, clonazepam, quetiapine Comments: Potential interaction between quetiapine and ziprasidone; continue to monitor CMP, serum creatinine for lithium and divalproex Recommendations: Clarify dx for clonazepam; TSH if not yet ordered PCP: Disagree – TSH levels are drawn q 6 months – due September Psychiatrist: - agitation and anxiety Discussion: The appropriate monitoring for lithium was not documented. There was no documentation of a UA or EKG. The dates of the lithium levels were not readable due to shading in table.		

#	Provision	Assessment of Status				Compliance
		98	6/24/11 6/24/11 7/5/11 7/20/11	• Risperdal, clozapine, famotidine, lorazepam, MVI, benztropine, trazodone Comments: Watch for potential drug interactions. Recommendations: None PCP: -- Psychiatrist: -- Discussion: Indicated that CBC should be done quarterly while on clozapine. Monitoring when stable is individualized but more often than quarterly.		
		300	6/6/11 6/6/11 7/15/11 7/20/11	• Triamterene/HCTZ, simvastatin, ferrous sulfate, quetiapine, risperidone, Vitamin D Comments: None Recommendations: Eval wt gain and dyslipidemia as potentially related to atypical antipsychotic; consider changing simvastatin to night dose; clarify indication for ferrous sulfate; continue to monitor for adverse drug reactions; BP well controlled PCP: Disagree; Agree; Agree; this is done regardless of physician or pharmacist recommendations Psychiatrist: -- Discussion: There was no clarification of the indication for ferrous sulfate in the response		
		217	6/8/11 6/8/11 7/13/11 7/22/11	• Loratadine, escitalopram, olanzapine, divalproex, Cal/D, clonazepam, lovaza Comments: Same as recommendations Recommendations: Please evaluate for antipsychotic induced wt gain; Last DEXA scan 12/23/08 indicated osteopenia; please consider alendronate PCP: Agree - Will defer to psychiatry Psychiatrist: Agree – will evaluate next f/u Discussion: Should be collaboration between medical and psychiatry regarding weight gain.		
		181	6/10/11 6/10/11 7/14/11 7/22/11	• Metformin, Humalog, amlodipine, esomeprazole, fluvastatin, bupropion, Lantus, buspirone, escitalopram, quetiapine Comments: None Recommendations: Please consider more aggressive insulin titration; Please consider addition of an ACE for renal protection and BP control; Bupropion likely worsening BP control – please consider separating doses. PCP: Disagree – See IPN; Agree – See IPN; Disagree see IPN; Psychiatrist: Disagree with Bupropion recommendation – See IPN Discussion: Unclear why diabetes medications are listed under the questions for psychoactive medications. There was no documentation of requirements for urine albumin and foot exam as part of the diabetes monitoring.		
		349	6/13/11 6/13/11	• Olanzapine, Iron/Docusate, Vitamin D, divalproex Comments: No lipid levels or Vitamin D found in chart.		

#	Provision	Assessment of Status				Compliance
				7/6/11 7/20/11	Recommendations: Individual taking Vitamin D. Did not see level in chart. PCP: Agree – see IPN Psychiatrist: -- Discussion: Obtaining lipids should have been a recommendation as part of the olanzapine monitoring. The worksheets stated appropriately monitored. Unclear why diabetes medications are listed under the questions for psychoactive medications.	
			538	5/9/11 5/9/11 6/2/11 NA	• Gabapentin, dilantin, Vitamin D, glipizide • Comments: Recommendations: Consider increase in dilantin due to sub-therapeutic level; PCP: Disagree - Please get all phenytoin levels; see orders Psychiatrist: NA Discussion: There were no recommendations related to diabetes monitoring such as adding ACE/ARB and checking urine microalbumin.	
			587	4/19/11 4/19/11 5/19/11 --	• Atorvastatin, carbamazepine, escitropl, alendronate, olanzapine, levothyroxine • Comments: Continue to monitor for adverse effects Recommendations: Consider decreasing dose of levothyroxine PCP: Agree – Dose decreased; will order repeat TSH Psychiatrist: --	
			432	5/5/11 5/5/11 6/21/11 NA	• Vitamin D, atorvastatin, esomeprazole • Comments: Monitor BMI, Dex, Ca and Vitamin D Recommendations: Consider increasing does of atorvastatin PCP: Agree – see IPN Psychiatrist: NA	
			26	5/9/11 5/9/11 6/7/11 NA	• Vitamin D, phenytoin, topiramate Comments: Monitor for AED side effects and labs Recommendations: MOSES/DISCUS due 4/30/11 but not in chart PCP: Agree with MOSES/DISCUS monitoring Psychiatrist: NA	
			311	5/20/11 5/20/11 6/20/11 NA	• Vitamin D, phenytoin. omeprazole • Comments: Neuro consult related to dilantin toxicity Recommendations: Individual with phenytoin toxicity possibly due to interaction with omeprazole. Discontinue omeprazole and re-evaluate PCP: Disagree – Keppra has been started and phenytoin will be tapered. Psychiatrist: NA	
			335	5/2/11 5/10/11 5/18/11 NA	• Atorvastatin, gemfibrozil, ferrous sulfate, lisinopril, dilantin, risperidone, alendronate • Comments: Neuro consult – sub-therapeutic dilantin Recommendations: Neuro consult noted increased risk of seizure due to sub-therapeutic levels. Dose was increased	

#	Provision	Assessment of Status	Compliance

		but no levels checked. Please check levels; consider adding metformin due to wt increase; consolidation of derm tropical agents PCP: Agree –we cannot draw; disagree – not at this time; disagree- followed by derm and well managed with regimen. Psychiatrist: No psych polypharmacy
249	6/13/11 6/13/11 7/5/11 NA	• Docusate Comments: See worksheet Recommendations: None PCP: -- Psychiatrist: NA
524	5/9/11 -- 6/7/11 NA	• Phenytoin, alendronate, carbamazepine, Vitamin D, Keppra • Comments: Continue to monitor Recommendations: None PCP: None Psychiatrist: NA
575	6/9/11 6/9/11 6/29 NA	• Loratadine • Comments: See worksheet Recommendations: None PCP: -- Psychiatrist: NA
448	6/14/11 6/19/11 6/29/11 NA	• MVI Comments: See worksheet Recommendations: None PCP: -- Psychiatrist: NA
570	5/12/11 5/12/11 6/10/11 --	• Keppra, lisinopril, atorvastatin, alendronate Comments: Monitor BP monthly, monitor urine protein Recommendations: Keppra at max dose – lease check level; last MOSES/DISCUS 1/2011 PCP: Agree – will check; M/D ordered

* -- Indicates no response or blank
** NA indicates the item was no applicable to the provider or that the provider checked the NA box

Additional Discussion

The facility included the worksheets as part of the official report. This resulted in the report being minimally, a six-page document. Several of the clinical pharmacists stated in the comments section to refer to the worksheets. In those cases, extracting information related to the monitoring of labs, polypharmacy, drug interactions, and other issues covered in the review required reading each of the questions. This approach to completing the QDRRs diminished the value of this necessary review. The QDRR should provide the medical provider with a concise drug review with the worksheets serving as the supporting information for the findings of the review.

#	Provision	Assessment of Status	Compliance
		Lab monitoring was completed in accordance with the lab matrix that was provided to the monitoring team. While the document indicated approval by the P&T Committee 3/11, the March 2011 meeting minutes did not record this approval. During interviews with the clinical pharmacists and acting pharmacy director, it was stated that approval of the matrix was on the agenda of the next P&T Committee meeting. It appeared that not all elements of the matrix were being used for monitoring. For example, a TSH was required annually for all individuals, but that standard was not used for monitoring. Additionally, the matrix provided monitoring parameters for individuals with diabetes mellitus. That standard was also not applied for the QDRR of the individual with diabetes. Other elements of the matrix are discussed in Section L above. The monitoring team highly suggests that the content of the matrix be reviewed and the document revised as deemed appropriate. The P&T minutes dated 6/29/11 noted that in the months of April 2011, May 2011, and June 2011, 62, 95, and 255 QDRRs were completed, respectively. This was an indication that there were issues in timely completion of the reviews. In the sample of QDDRs reviewed, there were substantial delays in the transfer of information. The timespan from the date of the review to the date of physician review often exceeded three weeks. In some instances, the delay was as much as four weeks. Moreover, the Health Care Guidelines required a review of the medication regimens every 90 days. Individual #335 had a review completed on 5/2/11. Based on the requirements, another review should have been completed by 8/2/11, but the review was not in the records as of late September 2011. The following individuals' records also did not have a current QDDR: Individual #538, Individual #587, Individual #432, Individual #26, Individual #311, Individual #335 and Individual #524. The failure to complete the reviews and provide the information to the providers in a timely manner had the potential to negatively impact health outcomes. This was demonstrated in the case of Individual #311 who was hospitalized in February 2011 with dilantin toxicity. The QDRR presented the hypothesis that a significant drug interaction resulted in the toxicity and there was a need for a medication change. The review was completed on 5/20/11. The physician reviewed the report on 6/20/11 and disagreed, stating that the dilantin taper was in progress. Although the clinical pharmacist noted that an ADR form would be completed, it was not clear that this potential drug interaction was communicated immediately and directly to the primary provider. If this was done, documentation of such actions should have been included in the report. Overall, the QDRRs contained some good information and feedback for medical providers. The monitoring parameters will require some clarification and revision. The pharmacy director should reconsider the inclusion of the entire worksheet as part of the	

#	Provision	Assessment of Status	Compliance
		report. 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 laboratory trends. Finally, timelines for completion of the process should be established for both the pharmacists and medical providers taking into consideration that the transfer of clinical information should occur in a prompt manner. Finally, any changes made in the process should be reflected in pharmacy polices and procedures.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of 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 monitoring team attended the Psychoactive Polypharmacy Review Committee meeting. This review of psychoactive medications by the psychiatrists did not include any true justification for the use of polypharmacy. Each psychiatrist went through the routine of why the individuals received the medications. There was no exploration of the necessity of the medications by the group. Psychoactive polypharmacy is discussed further in Section J. The lab matrix contained the monitoring parameters for the new generation antipsychotics and other medications. In the sample of QDRRs reviewed, it appeared that appropriate monitoring was completed. The clinical pharmacists surfaced a problem with the monitoring of labs associated with the use of Clozaril. It appeared that appropriate monitoring for the use of this NGA, although not specific to metabolic risks, did not occur in several instances. The current format of the QDRRs did not allow the monitoring team to assess if the frequency of laboratory monitoring was adequate because usually only one lab value was recorded. With the increase in reporting of adverse drug reactions, the NGAs were implicated numerous times with adverse events, such as weight gain and hyperlipidemia. Similar adverse events were detected through the QDRRs. While the associated risks were monitored and outcomes reported, there did not appear to be a response to the aggregate data that indicated a significant number of adverse drug reactions associated with the use of these agents. It would have been reasonable to expect further evaluation or possibly completion of a DUE based on this information. Additional discussion of NGA associated ADRs is found in Section N6.	Noncompliance
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	In order to determine substantial compliance with this provision item, the 27 QDDRs discussed in item N2 were assessed to determine the adequacy of the responses from both the primary providers and the psychiatrists. Data related to the primary provider response showed: • 27 of 27 (100%) documents included signatures of the primary care provider	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	indicating that review occurred • 19 of 27 (100%) reviews had recommendations made by the pharmacist • 13 of 19 (70%) reviews indicated PCP agreement with recommendation • 6 of 19 (32%) reviews indicated PCP disagreement with recommendation The psychiatric provider was also required to review the QDRRs: • 15 of 27 (56%) reviews involved the use of psychotropics • 14 of 15 (93%) reviews included signatures of the psychiatrist indicating that review occurred • 10 of 15 (67%) reviews included recommendations by the pharmacist related to the use of psychotropic agents • 6 of 10 (60%) reviews indicated the psychiatrist agreed with recommendation • 3 of 10 (30%) reviews indicated the psychiatrist disagreed with recommendation • 1 of 10 (10%) reviews had no response, although a psychotropic was involved All of the QDRRs reviewed contained notes when the medical provider disagreed with the recommendation. In fact, most contained notes to explain actions to be taken when there was agreement. This provision required that an entry be made in the IPN related to disagreement. Several QDRRs stated, "see IPN note."	
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 most recent MOSES and DISCUS evaluations included in the record sample were reviewed along with a sample provided with the document request. The findings are summarized below: Thirty-two MOSES tools were reviewed. The findings of the documents were: • 29 of 32 (90%) were signed and dated by the physician • 23 of 32 (72%) documented no action necessary • 9 of 32 (28%) documented no conclusion by the prescriber Thirty-three DISCUS evaluations were reviewed and showed that: • 31 of 33 (94%) were signed and dated by physician • 26 of 33 (79%) indicated no TD • 0 of 33 (0%) indicated TD • 3 of 33 (9%) documented no prescriber conclusion The MOSES evaluation was to be completed every six months while the DISCUS evaluation was required every three months. The DISCUS was required for individuals who received antipsychotics and Reglan. The MOSES was required for any individual who received antipsychotics or AEDs. Problems were identified with regards to accuracy	Noncompliance

#	Provision	Assessment of Status	Compliance
		and timeliness of the evaluations. The 6/29/11 Pharmacy and Therapeutics Committee meeting minutes noted the concern of one psychiatrist that the assessments were not being accurately completed. There were instances where lapses of one week, two weeks and, even two months occurred before the physician completed the review. The reason for the delay was not clear. This was also raised as an issue during the QAQI Council meeting on 9/22/11. <u>Additional Discussion</u> The MOSES and DISCUS assessments are intended to identify the development or presence of extrapyramidal symptoms and the potentially irreversible tardive dyskinesia, respectively. The completion and review of the evaluation should be considered more than an exercise in documentation. Consideration and discussion of all potential side effects, including the impact on the individual's quality of life should occur at each clinic contact. Information contained in these evaluation tools should be taken into consideration in the overall treatment and management of the individual. This information should be included in the transfer pack when individuals have neurology appointments.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The facility continued to restructure its Adverse Reaction Monitoring and Reporting system. The Naranjo probability algorithm was added to the ADR reporting tool and pharmacists received training on ADR reporting. The pharmacists and medical staff conducted monthly discussions related to ADRs. While it was good to see that the pharmacists and physicians were reporting ADRs, the system will require improvement in several areas. The Quarterly Suspected ADR Summary indicated, "MSSLC has only the most rudimentary elements of a well developed system." Individual ADR reports were reviewed in addition to two summary logs that recorded data from April 2011 through September 2011. The ADR reports were often incomplete and sometimes lacked that actual suspected drug. The summary reports contained the following documentation elements: date of incident, ID#, description of reaction, reporter, probability rating, severity, and FDA reportability. The log listed the medication and description in the same column. The entries for the month of April 2011 did not identify the actual drug suspected to cause the adverse reaction. It was sometimes difficult to identify the offending agent because educational comments were included. A few ADRs were reported multiple times on different days. Several ADRs were referred to the PCP for "an Intense Case Review." It was also apparent that the facility was not analyzing and trending data. All of the April 2011 entries failed to include the offending drug rendering that segment of data useless.	Noncompliance

#	Provision	Assessment of Status	Compliance
		One hundred twenty two ADRs were reported, 19 of which were possibly related to the use of new generation antipsychotic agents. Valproic acid was possibly responsible for another 12 reactions, while dilantin was linked to four. Lithium was the potential offending agent in six of the reported reactions. Analysis of the aggregate data should have resulted in a more detailed review of the use of the new generation antipsychotics. DUEs were completed on valproic acid and lithium. Discussion of those DUEs is found in Section N7. In order to develop a robust ADR monitoring and reporting system several actions are needed: • The facility should revise its ADR policy to reflect the use of the probability scale. There was no revision to the policy dated 2/17/11. • Physicians should be required to review all ADRs in their caseloads, not only those that need an intense case review. • Thresholds for the intense case review should be established. • All persons with significant contact with the individuals should receive appropriate training related to adverse drug reaction identification and reporting. • The data already reported should be reviewed for accuracy and corrected as deemed necessary. It should then be analyzed and examined for trends. When a drug is associated with frequent ADR reporting, further scrutiny is warranted to ensure that the facility is using the drug in the safest, most appropriate manner.	
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 implemented a new drug utilization evaluation policy, based on the Health Care Guidelines, in April 2011. Consistent with the policy, the Pharmacy and Therapeutics Committee established the frequency and of the evaluations and determined which drugs would be evaluated. One DUE was completed on a quarterly basis. DUE reports on lithium and valproic acid were provided for review. Both reports included background information, objectives, criteria, methods results, conclusions, and recommendations. Data collection forms were developed based on the Texas drug audit criteria and facility monitoring protocols. During the conduct of the evaluations, primary care physicians and/or psychiatrists were assigned to retrieve and review data. The physicians then forwarded the completed data collection forms to the clinical pharmacist who generated a summary report. The findings were presented to the P&T Committee. <u>DUE #1 – Lithium</u> April 2011 – June 2011 The objective of the DUE was to evaluate proper use of lithium based on FDA	Noncompliance

#	Provision	Assessment of Status	Compliance
		recommendations and clinical indications, evaluate whether the appropriate monitoring was conducted, assess possible adverse reactions, and provide recommendations on appropriate use and monitoring for lithium. The medical director selected seven individuals. Each physician reviewed one individual and forwarded the findings to the clinical pharmacist. Overall, monitoring was completed. One individual was not taking lithium at the time of the DUE. None of the individuals took lithium with food as recommended. All of the individuals had potential drug interactions with other psychotropics. Compliance with lab monitoring parameters was reported: • 5 of 7 (71%) individuals had annual EKG completed • 7 of 7 (100%) individuals had an annual CBC • 2 of 7 individuals (29%) had appropriate TSH monitoring • 6 of 7 individuals (86%) had appropriate electrolyte monitoring The conclusion section cited substantial achievements as well as opportunities for process improvement. The recommendations section provided extensive information on drug-drug interactions. The P&T Committee meeting minutes documented that nursing would have the case managers review the issue of GI disturbances. <u>DUE #2 – Valproic Acid</u> July 2011 – September 2011 The objective of the DUE was to evaluate drug usage treatment and monitoring of valproic acid, appropriateness of the prescribed dose, and the nature and incidence of adverse drug reactions associated with valproic acid use. Twenty individuals receiving valproic acid were preselected. Physicians reviewed data and submitted the findings to the clinical pharmacist. Sixteen individuals had side effects including agitation, headache, and tremor. Blood dyscrasias were also reported. Compliance with lab monitoring parameters was reported: • 20 of 20 (100%) individuals had annual CBC, liver enzymes, and BMP • 16 of 20 (80%) individuals had appropriate monitoring of platelet counts • 20 of 20 (100%) individuals had appropriate monitoring of drug levels The DUE concluded that the use of valproic acid was associated with a relatively low rate of ADRs and monitoring was usually appropriate. The recommendation was to continue monitoring and reporting, and completion of follow-up on any changes with monitoring parameters.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Additional Discussion
Both the drug selection and content of the DUEs was good and valuable educational information was provided. Overall, high rates of compliance were noted with most of the monitoring parameters and that was good to see. The DUE process did have some areas that were worthy of additional attention:
The process of determining sample size was not clear for either study. The validity of the study is impacted by the sample size.
The results of the study were not entirely consistent with other data reported by the facility. ADR data reported from April 2011 through September 2011 included multiple possible adverse drug reactions attributed to valproic acid (10%) and lithium (5%).
Physicians completed the actual audits. It was reported that no physician audited his or her own records. Even so, it would be more appropriate to have the clinical pharmacist conduct the audits to ensure complete neutrality and lack of physician bias.
The lithium DUE did not outline the criteria to be used within the content of the report.
While valuable information was generated by the studies, in those instances when problems were noted, there was no evidence that a corrective action plan was generated. Specifically, compliance rates for monitoring EKGs and TSH levels required a specific plan of correction.</td><td></td></tr>
<tr><td>N8</td><td>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.</td><td>The facility maintained processes for monitoring and reporting medication errors. The medical director chaired the Medication Error Review Committee (MERC) which met bi-weekly to review analyze and trend errors. The number of errors reported monthly was variable. Data taken from the MERC summaries provided to the monitoring team is summarized in the chart below.
<table><tr><th colspan="8">Medication Errors 2011</th></tr><tr><th></th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th></tr><tr><td>Total Errors</td><td>30</td><td>26</td><td>79</td><td>77</td><td>56</td><td>38</td><td>30</td></tr><tr><td>Prescribing</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>13</td></tr><tr><td>Administration</td><td>23</td><td>21</td><td>68</td><td>75</td><td>54</td><td>34</td><td>19</td></tr><tr><td>Documentation</td><td>7</td><td>3</td><td>9</td><td>2</td><td>7</td><td>1</td><td>4</td></tr><tr><td>Monitoring</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td><td>1</td><td>1</td></tr><tr><td>Dispensing</td><td>5</td><td>4</td><td>4</td><td>1</td><td>2</td><td>4</td><td>1</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Administration Errors							
Wrong patient	0	0	2	3	0	0	1
Wrong dose omissions	24 (20)	15 (14)	55 (51)	57	41	18	
Wrong dose form	1	0	0	0	0	0	9
Wrong drug	0	2	0	1	1	0	2
Wrong time	0	1	5	0	0	0	0
Improper dose	2	3	12	8	34	19	4
Extra dose	3	5	4	7	3		3
Pharmacy Returns							
Returned Medications	653	987	742	870	870	870	743
Reconciliation Rate (%)	37	28	27	30	30	30	85

Omissions were the most frequently occurring error. The CNE believed that this was linked to the current unit dose dispensing system. Moreover, there was evidence that nurses did not consistently use the MARs appropriately during medication administration. A pilot was implemented in one home, which involved the bagging of medications. The CNE reported that other SSLCs were separating medications into baggies for each medication pass and this appeared to decrease errors. The effectiveness at MSSLC had not been determined. There was one category F error in March 2011, which resulted in hospitalization of an individual due to tegretol toxicity. The individual was reported to have a full recovery.

Medication pass audits were completed on a regular basis and numerous issues were repeatedly identified during these audits including:

- Blanks found on the MARs
- MARs not verified for accuracy by nursing staff
- MARs failing to identify allergies
- MARs with no start/stop dates
- Failure to check medication three times prior to administration
- Failure to identify the individual up to point of administration
- Failure to secure medication cart
- Pharmacy's failure to identify the specific number of pills to administer
- Medications were not documented as they were administered

#	Provision	Assessment of Status	Compliance
		Most of these problems were addressed though education and staff training. In addition to training, there were numerous strategies implemented to decrease the number of variances: • Nursing administration explored alternative medication administration systems. • A new medication return count form was implemented which required daily completion. • Nurses began noting orders in red ink to ensure that orders were not missed. • LVN med passes were unannounced. • The pharmacy changed descriptions on MARs to note exactly what should be given. The pharmacy continued to have a high rate of medications returned with no explanation. Data for August 2011 were presented in the MERC meeting and, based on the data presented, it was determined that a significant improvement had occurred. This sudden and dramatic decrease warranted further review and validation of data. Moreover, it appeared that the data recorded for the months of June 2011 and July 2011 were duplicated and will require correction. While the problem of reconciliation of pills was reviewed through the pharmacy overages data, it became clear that there was no similar process to reconcile liquid medications. The monitoring team pointed out that there was evidence that the MARs, at times, were used improperly and this contributed to the omission errors. A lack of use of the MAR would also increase the probability that liquid medications were not administered. In order to capture errors related to liquid medications, the facility would need to implement some element of reconciliation of liquid medications. In the absence of reconciliation of all medications, the true medication error rate was not known. The clinical pharmacist stated in the Quarterly Clinical Pharmacy Report, "The importance of unexplained missing and returned doses cannot be understated. This is an extremely important aspect of quality of patient care. The potential for serious failure of any medication regimen, exists due to extremely high probability of missing doses. Failure to identify and correct missing and unexplained doses could place our patients and facility at risk. This should be an urgent priority of the Medication Safety Sub-Committee, the Quality Assurance Office, the Director of Pharmacy, the Director of Nursing and coordinated by the Medical Director." At the time of the onsite review, the Quality Enhancement Department did not appear to have a significant role resolving this issue. Data integrity also proved problematic for the facility. During the September 2011 MERC meeting, the QA nurse reported that some errors had been incorrectly counted which	

#	Provision	Assessment of Status	Compliance
		meant the data presented were not accurate and the number of variances was actually higher. The monitoring team requested information on the data validation process and was informed that data were not consistently validated. Accurate data analysis cannot occur in the absence of reliable data. Corrective actions must be driven by reliable data and proper data analysis. The monitoring teams believed that the facility must take several steps to ensure a safe medication use system: • The problem of medication errors, unreconciled returned medications, and data management should be prioritized for immediate corrective actions. • The facility should develop strategies to improve the reliability of reported data. Data validation would be one such strategy. • Compliance with safe medication practices will require that the facility move beyond the current medication error system. Every point in the Medication Use System must have appropriate strategies in place that allow for detection of medication variances. All variances that occur in the system, from prescribing through dispensing, administering and monitoring should be reported. • The Quality Enhancement Department should take an active role in defining the problems, developing, implementing and following up on solutions relative to medication variances.	

Recommendations:

1. The pharmacy must document all interactions between the pharmacists and the clinicians. Documentation should include resolution of problems (N1).

2. The pharmacy director must discuss the documentation requirement with all pharmacists that participate in the dispensing of medications (N1).

3. The policy Safe Medication Practices must be revised:
    a. The revision should be reflective of the actual processes that occur in the department as well as the tools that are utilized.
    b. The various documentation tools should be evaluated to determine if multiple tools are necessary.
    c. If multiple tools are necessary, the policy should provide the criteria for their use(N1) .

4. Pharmacy intervention data should be consistently collected and analyzed. The medical director should regularly discuss this data with the medical staff, counsel physicians as necessary and provide educational opportunities based on data analysis and needs assessments. Systemic issues identified as a result of data analysis should also be addressed (N1) .

5. The facility will need to determine how to achieve compliance with the requirement for the prospective review of labs. The use of Avatar

should be explored (N1).

6. The pharmacy director should review reporting and documentation patterns and ensure that all pharmacists who participate in the prospective review of physician orders are appropriately documenting the communication with prescribers as required in the Health Care Guidelines (N1).

7. The medical director should review the lab matrix and ensure that guidelines are consistent with the facility's adopted standards of care. Once approved, training should be provided to appropriate staff including medical providers and case managers (N2) .

8. Consideration should be given to removing the QDRR worksheet as part of the actual report. The information contained in the worksheet should be summarized in the report. If an individual receives medication for a condition and there is laboratory monitoring for that condition, the values should be reported, preferably in tabular format. Lab values should be documented even when normal and reference values should be provided. The frequency of lab ordering should be in accordance with the facility's lab matrix or as clinically indicated (N2).

9. The facility should take multiple actions with regards to the ADR reporting and monitoring system:
    a. The ADR policy should be revised to incorporate the use of the probability scale, intensity scale and requirement for an intense case analysis.
    b. The ADR policy should specify how the reporting form is completed.
    c. The ADR summary log should be revised in a manner that lends to adequate data analysis. One way of accomplishing this is to utilize a simple spreadsheet that provides data on the specific drug, drug type, and reaction type (allergic, blood dyscrasias, elevated liver enzymes, etc.), in separate columns. Further description of the event and other comments could be put in a separate column. This would allow sorting by specific drug, drug type and drug reaction.
    d. The ADRs should be reviewed outside of the P&T Committee and a summary forwarded to the Committee for review and discussion. The weekly medical meetings provide an opportunity to review ADRs as they occur.
    e. The P&T minutes should reflect corrective actions taken as a result of problems noted with the ADR system. When problems are noted, a corrective action plan should be developed that provides action steps, responsible persons, and timelines for completion (N2).

10. The facility should consider increasing the frequency of the P&T meetings. The committee currently meets quarterly. The agenda contains approximately 14 standing items including issues related to pharmacy operations, billing, infection control, DUEs, QDRRS, ADRs, psychotropic polypharmacy, clinical interventions, and medication errors. Many of these items cannot be adequately addressed in a two-hour meeting (N2) .

11. The facility must take several steps in advancing the medication variance system:
    a. Data reliability must be addressed. Medication error data should be validated on a monthly basis.
    b. The facility must address the potential for medication errors for all forms of medications. This will require some system of reconciliation of liquid medications.
    c. As noted by the clinical pharmacist, the facility must consider the large number unreconciled returned medications an urgent priority. The Quality Enhancement Department should consider providing assistance to the pharmacy, nursing and medical departments.
    d. The facility must implement strategies and systems that allow for detection of medication variances at every step of the medication use system (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o MSSLC Organizational Chart o Individuals Served- Alpha o Admissions list o Physical Nutritional Management MSSLC Policy #18 (8/30/11) o Textured Modified Diets MSSLC Policy Nutrition Services #12 (8/15/11) o MSSLC Procedures: Safe Practices for Correcting Common Errors in Food Texture/Consistency, Measurement of Fluid Levels, and Oral Suction Toothbrush o Section O Presentation Book and POI o Settlement Agreement Cross-Reference with ICF-MR Standards Section O-Physical Nutritional Management o Settlement Agreement Section O: Physical Nutritional Management Audit forms submitted o PNMT member list o CVs/resumes for PNMT members o PNMT Continuing Education documentation o List of hospitalizations/ER visits o PNMP Monitoring form template o PNMP Monitoring Data Base o Completed PNMP Monitoring Forms submitted o Completed Validation monitoring forms submitted o NEO training curriculum for PNM o PNMP Training Roster o PNMP Task Analysis Reference Lists o List of Risk Levels for Choking, Falls, Skin Integrity, GERD, Constipation, Osteoporosis, Aspiration, Respiratory (Low, Medium, High) o Dining Plan template o Dining Plans and training sheets submitted o Individuals with Modified Diets/Thickened Liquids o Individuals with diet downgrades in the past 12 months o List of individuals with poor oral hygiene o List of individuals with chronic respiratory infections in the last 12 months o List of individuals with a choking incident in the past 12 months o Follow-up documentation related to choking incidents since the previous review (Individual #8 and Individual #94) o List of individuals with fecal impaction in the last year o Individuals with BMI equal to or less than 20

	o Individuals with BMI equal to or less than 30 o Individuals with unplanned weight loss of 10% or greater over six months o Individuals with chronic dehydration o Pneumonia Diagnosis o Falls o Individuals Taking Pain Medications o List of individuals with enteral nutrition o List of individuals who require mealtime assistance o List of individuals receiving MBSS/VFSS in the past year o Aspiration Pneumonia/ Enteral Nutrition Evaluations for: • Individual #266, Individual #407, Individual #518, Individual #293, Individual #474, Individual #16, Individual #72, Individual #61, Individual #226, Individual #196, Individual #306, Individual #302, Individual #512, Individual #151, Individual #35, Individual #578, Individual #285, Individual #395, Individual #175, Individual #220, Individual #435, Individual #369, Individual #197, Individual #542, Individual #511, Individual #328, Individual #79, Individual #314, Individual #38, Individual #257, Individual #188, Individual #528, and Individual #515. o Pressure Wounds from July 2010 to August 2011 o Fractures o Individuals who were non-ambulatory or require assisted ambulation o People Who Use Wheelchairs for Mobility Only o People Who Use Wheelchairs for Positioning and Mobility o List of individuals who receive enteral nutrition o List of individuals using Ambulation Assistive Devices o PNMPs submitted o PNMT Evaluation for Individual #435 o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QMRP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #542, Individual #72, Individual #490, Individual #474, Individual #304, Individual #518, Individual #197, Individual #588, Individual #257, Individual #524, Individual #391, Individual #99, Individual #494, Individual #151, and Individual #266. o PNMP section in Individual Notebooks for the following: • Individual #542, Individual #72, Individual #490, Individual #474, Individual #304, Individual #518, Individual #197, Individual #588, Individual #257, Individual #524, Individual #391, Individual #99, Individual #494, Individual #151, and Individual #266. o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12

	months for the following: • Individual #542, Individual #72, Individual #490, Individual #474, Individual #304, Individual #518, Individual #197, Individual #588, Individual #257, Individual #524, Individual #391, Individual #99, Individual #494, Individual #151, and Individual #266. Interviews and Meetings Held: o Brandie Howell, OTR, Habilitation Therapies Director o PNMT members o PNMP Coordinators o Various supervisors and direct support staff Observations Conducted: o Living areas o Dining rooms o Day Programs o Work areas o PNMT meeting for Individual #435 o Risk Meeting with Monitoring Team
	Facility Self-Assessment: MSSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Habilitation Director review the Presentation Book onsite and a copy was submitted for review per request. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements related to a variety of tasks since completed. Also, there was no mechanism to determine how the facility had determined noncompliance with six of eight items in this provision. They indicated that they were in substantial compliance with provisions O3 and O4. While the monitoring team concurred that the plans were improved, the content related to oral hygiene and medication administration were not completed related to position. Also implementation by staff was not adequate at this time. Appropriate and consistent implementation is a key element to this provision. A blank Settlement Agreement Cross-Reference with ICF-MR Standards Section O- Physical Nutritional Management self-audit tool and Guidelines were included in the Presentation Book and completed audits were submitted. It did not appear, however, that the audits were used to determine compliance with the provisions. A list of action steps were included in the POI as follows: • O3: 17 of 17 actions completed • O5 and O6: 13 of 14 actions completed, development of a training curriculum for PNMPCs was identified as in process with a projected completion date of 3/1/12

	• O8: four of four actions completed Though these were listed as complete, the monitoring team did not always agree. For example, for O8.1 (evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary), those assessments were incomplete and inadequate. They did not reflect an interdisciplinary approach to this review process. The actions listed in the plan did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. This approach appeared to merely document completion of tasks rather than to serve as clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be short-term, and stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. It was not clear what these specifically related to and how the trend analysis submitted would constitute completion of the review data action or that sign in sheets would sufficiently demonstrate that staff had been adequately trained. Though improvements were evident, the monitoring team found that MSSLC continued to be in noncompliance for each of the items in provision O.
	Summary of Monitor's Assessment: The Habilitation Therapies department demonstrated a lot of effort with a substantial number of work products produced related to this provision and to section P below. There were many new systems initiated. The Director clearly reviewed the previous report for all related sections and developed strategies to address issues identified. The PNMT at MSSLC was a fully constituted, dedicated team at the time of this review. While a number of meetings had been held since the previous review, the team had completed an assessment for only one individual. There was, however, no action plan developed. The facility was significantly behind in the development of this team. The PNMPs were of a consistent format and each was current within the last 12 months. MSSLC had incorporated instructions related to bathing for some, and for oral hygiene and medication administration for most, individuals. The content of these sections was limited, however, and consideration of positioning, presentation strategies, utensils needed, and additional instruction is recommended. Implementation of these plans, while improved, continued to be problematic and staff did not understand the rationale for the strategies they were instructed to apply. In addition, there was no evidence that a strong skills-based competency training for elements of the plans was provided. Positioning and transfers continued to be a concern. Supervisors and monitors were not recognizing the problems and/or were not take sufficient corrective actions to address them. PNMP monitoring must also address the question of whether interventions are effective. Waiting to develop a curriculum for training the PNMPCs until March 2012 will

	not be an effective strategy. The PSTs will require ongoing 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. A meeting related to the risk assessment process with one PST was conducted by the monitoring team during the week of this onsite review with significant discussion about strategies for the team to consider as they implement this policy. Further evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks.

#	Provision	Assessment of Status	Compliance
01	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** MSSLC formally initiated the new process for the Physical Nutritional Management Team (PNMT) by assigning dedicated team members as of 9/1/11 The nurse position was filled on 7/1/11. Core team members at the time of this onsite review were Brandie Howell, OTR Chair, Director of Habilitation Therapies; Janis Pair, RN; Frances Harman, MS, CCC-SLP; Christopher Ross, OTR; Sandra Opersteny, PT, Assistant Director of Habilitation Therapies; Jennifer Capers, LD; and Christopher Ellis, MD. Only these team members attended the meeting observed by the monitoring team. Minutes or other documentation for previous meetings were not submitted. Resumes/CVs were submitted for each of the team members listed. The resumes/CVs submitted indicated that each of these clinicians had at least three years of experience with individuals who had developmental disabilities with the exception of Christopher Ross. He received a Master of Science in Occupational Therapy in December 2003 with employment at retirement center and a PRN position at a hospital. Skilled OT services for individuals with DD were listed, but the length of this position was not identified.. PNM-related continuing education documented since the previous review included the following: Risk Management training and PNMT training by Karen Hardwick, Pressure Ulcer Management Addressing Extrinsic Risks, Introduction to PNMT, Introduction to Assessment Technologies, and Introduction to GI/Dysphagia. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** The PNMT had not met regularly at the time of this review. No meeting minutes or other documentation was submitted for any meetings held since the previous review in March	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	2011. An assessment for Individual #435 had been initiated and a meeting held to review the information was held during the week of this review. The completed report was submitted by the facility a couple of weeks after the onsite review by the monitoring team. There was no action plan developed as was required by the state policy.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has 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.	**Standard: A process is in place that identifies individuals with PNM concerns.** Based on the number of PNMPs submitted, there were 246 individuals identified with PNM needs at MSSLC, or, 88% of the current census (278). A policy and process used to establish health risk levels was implemented statewide in January 2011. The goal was to have discussions of risk occur during each individual's PST meetings. At the time of this review, the teams were continuing to work toward integrating this into the PSP process that had been initiated in the Fall 2010. The PSTs will require ongoing clinical instruction and support regarding risk assessment and real time modeling by state leaders (as was the plan) to effectively implement these policies and procedures. A meeting related to the risk assessment process with one PST was conducted by the monitoring team during the week of this onsite review with significant discussion about strategies for the team to consider as they implement this policy (for Individual #524). Continued evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks. 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 had initiated two assessments, only on individuals who had been referred (Individual #435 and Individual #542). Individual #542 had just been referred on 9/15/11, so the assessment was	Noncompliance

#	Provision	Assessment of Status	Compliance
		reportedly in process. There were a number of individuals with multiple PNM-related risk factors or issues who potentially would benefit from the coordinated, comprehensive supports and services of the PNMT. The monitoring team is providing this level of detail in hopes that it will assist the facility to attend to their risks and PNM needs. • There were 278 (71% of the current census) individuals identified with PNM needs and were provided a PNMP. • There were 113 (21%) individuals with poor oral hygiene in the last six months. Of these, Individual #515 and Individual #407 were diagnosed with pneumonia or aspiration pneumonia in the last six months. • There were 23 (6%) individuals with 56 incidences of skin breakdown in the past year. One of these were listed as unresolved (Individual #304 since 7/22/11). There were 16 of these individuals who required a wheelchair for their primary means of mobility and positioning. Of these, only Individual #515 (8 incidents) and Individual #474 (3 incidents) were listed at HIGH risk for skin integrity concerns. Eleven others were identified at MEDIUM risk. Of these, Individual #518 (5), Individual #538 (2), Individual #43 (2), Individual #16 (6), and Individual #72 (5) had experienced multiple incidents of pressure wounds. Ten individuals were listed with one or more incidents of pressure wounds, but were not listed as at risk for skin integrity concerns. • There were 81 (21%) individuals who were obese with a BMI of 30 or over and 12 of these had a BMI over 40. • There were 13 (3%) individuals with a BMI less than 20, with five of these with a BMI under 18.5 (underweight). • There were eight (2%) individuals listed with unplanned weight loss. These individuals had lost more than 10% of their weight in six months' time. • There were eight choking events since 9/16/10 for six individuals. With one exception (Individual #525), each of these individuals required abdominal thrust. Individual #567 (9/23/10 and 5/18/11) and Individual #431 (3/30/11 and 7/4/11) were listed with two separate incidents each. Individual #567 was listed at HIGH risk of choking, yet Individual #431 was not listed at risk at all, despite two choking incidents in a four-month period. Individual #525 was listed at medium risk despite an incident of choking on 3/2/11. There were six (2%) individuals listed as HIGH risk for choking and 52 individuals (13%) listed at MEDIUM risk for choking. One other individual, Individual #467, was listed with a choking event on 6/1/10, just over one year ago and yet was listed at LOW risk for choking. Three other individuals who had experienced choking events since June 2010 were no longer listed as residents at MSSLC. • There were 60 (15%) individuals with a diagnosis of dysphagia.	

#	Provision	Assessment of Status	Compliance
		• There were 213 (54%) individuals who required assistance at mealtime. • There were 102 (26%) individuals with modified diet textures and 53 (14%) with thickened liquids. At least 28 (7%) individuals' diet texture had been downgraded in the last 12 months. • There were 33 (8%) individuals who were enterally nourished. Six of these individuals were also listed with pneumonia (four of these were aspiration pneumonia) in the six months. Only one of these received some level of oral intake (Individual #61). • There were approximately 10 (3%) individuals with pneumonia in the last six months. Six of these were diagnosed with aspiration pneumonia. There were 11 (3%) individuals listed at HIGH risk for aspiration. Of those with aspiration pneumonia, only two (Individual #435 and Individual #151) were identified at HIGH risk and five others were listed at MEDIUM risk for aspiration. Individual #588 and Individual #131 each had an occurrence of aspiration pneumonia but were not considered at risk for this significant issue. There were 11 individuals listed at HIGH risk for aspiration and 82 at MEDIUM risk. • There were 65 (17%) individuals identified as non-ambulatory and another 64 individuals who required assistance for ambulation and/or transfers. • There were 31 (8%) individuals listed with contractures. None of these participated in OT or PT services to address this concern. • There were 71 (18%) individuals who used a wheelchair as a primary means of mobility. • There were 18 (5%) individuals who used assistive equipment for ambulation. • There were 30 (8%) individuals who used transport wheelchairs as needed. • There were 102 (26%) individuals with upper or lower extremity orthotics. • There were approximately 123 (31%) individuals who had experienced one or more falls in the last year. At least 20 of these individuals were seated in a wheelchair for mobility and/or positioning. o There were 33 individuals with two or more falls who required assistance for ambulation and/or transfers. Individual #588 (8), Individual #533 (1), Individual #117 (3), and Individual #272 (1) were each listed as non-ambulatory. o There were only eight individuals listed at HIGH risk for falls: Individual #518 (0), Individual #281 (6), Individual #140 (1), Individual #120 (5), Individual #588 (8), Individual #438 (3), Individual #56 (2), and Individual #377 (3). o There were 61 individuals identified at MEDIUM risk for falls, yet a number of them had experienced four or more falls: Individual #99 (27), Individual #390 (4), Individual #494 (7), Individual #514 (4), Individual #231 (3), Individual #278 (12), Individual #303 (7), Individual #156 (3),	

#	Provision	Assessment of Status	Compliance
		Individual #108 (3), Individual #567 (13), Individual #117 (3), Individual #185 (3), and Individual #587 (6). o There were 56 individuals who were listed with four or more falls. Only three of them had been identified at HIGH risk for falls. Individual #359 (22), Individual #217 (12), and Individual #24 (22), were not listed at risk for falls despite each having had more than 10 falls documented. • There were 26 (7%) individuals who sustained an injury resulting in a fracture in the last year. Eleven of these individuals had experienced multiple falls. Five used a wheelchair or required assistance for ambulation (Individual #120, Individual #494, Individual #202, Individual #361, and Individual #222). • There were 34 (9%) individuals listed at HIGH risk for osteoporosis. There were 75 (19%) others listed with a MEDIUM risk for osteoporosis. • There were 65 (17%) individuals admitted to the hospital in the last year, 27 who had two or more hospitalizations. Individual #432, Individual #518, Individual #540, Individual #278, Individual #72, Individual #444, Individual #96, and Individual #295 each had three hospitalizations. Individual #524, Individual #435, Individual #188, and Individual #257 had four. Individual #542 and Individual #79 each had five, Individual #515, Individual #38 had six and Individual #151 and Individual #490 each had seven. A number of ER visits were also PNM-related issues or diagnoses. • There were 258 (66%) individuals listed as prescribed pain medications. The complexity of PNM-related risk indicators requires comprehensive and collaborative team assessment, intervention plan development, implementation, and monitoring. The current system of risk identification continued to be problematic.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that	**Standard: All persons identified as being at risk and requiring PNM supports are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).** As stated above, there were approximately 278 individuals identified with PNM needs provided with PNMPs. The PNMPs were generally of a consistent format and contained information related to the focus, hearing, vision, mobility, transfers, positioning, bathing/skin care, mealtime instructions, behavior concerns, precautions, risk level, and communication. Each of the plans now also referenced oral hygiene and medication administration. The monitoring team selected 15 individuals for a record sample (included in the above list of documents reviewed). Comments are provided in detail below in hopes that the information will be useful to the facility. Overall, this was a very good set of PNMPs. As noted throughout this section of the report, improvements in implementation will be	Noncompliance

#	Provision	Assessment of Status	Compliance
	are likely to provoke swallowing difficulties.	needed: • PNMPs were submitted for 15 of 15 (100%) individuals included in the sample. • PNMPs for 15 of 15 individuals in the sample (100%) were current within the last 12 months. • In 15 of 15 PNMPs reviewed (100%), positioning was addressed. • In 12 of 12 PNMPs reviewed (100%) for individuals who used a wheelchair as their primary mobility, some positioning instructions for the wheelchair were included. • In 15 of 15 PNMPs reviewed (100%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 15 of 15 PNMPs reviewed (100%), the PNMP listed bathing instructions and listed equipment when needed. Some of the plans identified the number of staff needed for bathing, others identified the position. The PNMPs consistently listed the equipment needed. Only one of the PNMPs reviewed provided toileting instructions. • In 100% of the PNMPs reviewed for individuals who were not described as independent with mobility or repositioning, handling precautions or instructions were included. • In 15 of 15 PNMPs reviewed (100%), instructions related to mealtime were included. Dining plans were also submitted for 15 of 15 individuals included in the sample as requested by the monitoring team. • 8 of 15 individuals (53%) received enteral nutrition. Instructions for no oral intake were clearly stated in the PNMPs for each. • In 13 of 15 PNMPs reviewed (80%), dining position for meals or enteral nutrition was provided. • In 0 of 8 PNMPs reviewed (0%), diet orders for food texture were included for those who ate orally. Assistance techniques for oral intake were consistently provided in the plan. • In 1 of 8 PNMPs for individuals who received liquids orally (13%), the liquid consistency was clearly identified. • In 4 of the 8 PNMPs for individuals who ate orally (57%), dining equipment, regular dinnerware and utensils were not specified in the dining equipment section. • In 15 of 15 PNMPs reviewed (100%), a heading for medication administration was included in the plan. The content provided varied from plan to plan. • In 15 of 15 PNMPs reviewed (100%), a heading for oral hygiene was included in the plan. The content provided varied from plan to plan. • 15 of 15 PNMPs (100%) reviewed included a heading related to communication. The information merely was as statement of verbal or nonverbal with reference	

#	Provision	Assessment of Status	Compliance
		to use the Communication Dictionary. Specifics regarding expressive communication or strategies that staff could use to be an effective communication partner were not provided in any case. The primary intent of addressing oral care in the PNMP is to ensure appropriate position and, most importantly, proper alignment during oral hygiene/tooth brushing activities conducted by the direct support professionals several times daily. Another critical issue is related to whether the individual required thickened liquids or special techniques to assist with swallow/breathe synchrony. This is critical to ensure effective oral hygiene in a manner that is safe for those at risk for aspiration. There were no written instructions or pictorial support to direct staff in oral care strategies and techniques. There was also limited information related to mediation administration. **Standard: PNM plans were incorporated into individual's Personal Support Plans.** One of the 15 PSPs submitted for the individuals included in the sample was not current within the last 12 months (Individual #490, 8/2/10). PSP meeting attendance by PNM professionals was as follows for the 15 PSPs included in the sample selected by the monitoring team (also see section F above): • Medical: 4 of 15 (27%) in attendance per the signature sheet. • Dental: 0 of 15 (0%) in attendance • Nursing: 15 of 15 (100%) in attendance • Physical Therapy: 6 of 15 (40%) in attendance • Nutrition: 4 of 15 (27%) in attendance • Communication: 6 of 15 (40%) in attendance • Occupational Therapy: 5 of 15 (33%) in attendance It would not be possible to achieve adequate integration given the limitations in PNM-related professional participation in the PST meetings. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective support plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** As stated, above poor attendance at PSP meetings and the lack of integration in the PSP negatively impacted the ability to develop the PNMPs in a comprehensive and collaborative manner.	

#	Provision	Assessment of Status	Compliance
		Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed. The Physical Nutritional Management Plan was referenced in each of the PSPs reviewed, however, there was no real evidence that the team had reviewed the elements of the plan. Typically, there was a general statement that it was reviewed and that updates would be made, but the specific strategies with rationale were not outlined in the PSP. In most cases, the equipment prescribed in the PNMP was also listed in the PSP. The PNMP was not well integrated into the individual's PSP as a result. There was evidence in each of the annual OT/PT assessments that the PNMPs were reviewed by therapy clinicians, however, there was no evidence of review by the PST in relation to identified risk and the efficacy of the interventions implemented. In some cases, statements from the assessments were included in the PSP, but there was no element that indicated the information was discussed or that the PNMP was reviewed by the full PST. The PNMPs were updated by the therapy clinicians based on change in status or need identification and indicated in the plan by the revised date, the PSP date (annual) and by highlighting of new instructions that were added to the previous plan.	
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 with limited input by other PST members. Generally, the PNMP was located in the individual notebook in the back of an individual's wheelchair, if he or she had one, or was to be readily available nearby, otherwise. In most cases, pictures were available with the PNMPs related to adaptive or assistive equipment as well as various positioning outlined in the plan. These pictures were large and easy to see. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright, and described the angle of recline, seatbelt use, and the type of transfer to be used. General practice guidelines with regard to transfers, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation, but not generally specified in the PNMPs. Dining Plans were noted to be available in the dining areas. Though improved since the previous reviews, errors were noted in staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP and/or Dining Plans.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A number of examples are presented below in hopes that this detail will be useful to the facility: • Individual #377: Her dining plan stated that she required two swallows per bite. The staff member assisting her offered several bites in succession and was not able to recognize a swallow. • Individual #231: She was to be seated upright in her wheelchair for the meal. She was noted to be slumped down in her wheelchair before a meal. When prompted to correct this, staff stated that she slumped down no matter how many times you corrected her. • Issues related to chopped chicken were noted for Individual #172, Individual #365, and Individual #77. There were inconsistencies between the Dining Plan and the Diet Card. • Individual #502: He was to be offered a partial glass of beverage only. Staff assisting watched him pour a full glass and did not intervene. When questioned about this, staff responded that he was independent and had to be prompted to make a correction. • Individual #47: Staff spoke to him in a very inpatient tone of voice. He repeatedly touched or pulled at the waistband of his pants. She told him numerous times that it was not appropriate and instructed him to put his hands down. Her voice became louder and sounded frustrated each time. When asked if he had a behavior plan she indicated that she did not know. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** Though improvements were certainly noted, 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 addition, staff were not able to recognize when alignment was inappropriate in order to remedy or report it as a problem. When prompted, they were generally not able to make the appropriate corrections, requiring significant coaching (also see other examples in section P below). In addition, when staff were asked questions as to why an individual had honey-thick liquids or a particular spoon, they were generally not able to answer appropriately. A number of staff stated "aspiration" or "swallowing" (a safe answer), but could not provide specifics why honey thick would be a safer liquid consistency, for example. Staff were not able to provide the justification for some equipment, such as orthotics or shin guards. Staff were not able to identify health risk indicators for the individuals they supported.	

#	Provision	Assessment of Status	Compliance
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.** Staff training for New Employee Orientation related to PNM pertained predominately to the mealtime aspect of supports with very little content evident related to physical management supports, position, alignment and transfers. After participation in the training, a check-off was conducted with the staff to establish competency in some of these areas. A tremendous amount of content was to be presented with the intent of establishing competency in a short time in NEO. It will be necessary to increase the amount of time new employees have for the PNM aspects of their training and competency check-offs. There was no evidence in the training documentation for Dining Plans or PNMPs that the individual-specific training that was provided was competency-based by return demonstration. Skills-based competency testing should involve an outline of each of the steps necessary to complete the task and each would be checked off as it was correctly completed by the participant. Checklists must be sufficiently discrete so as to ensure proper evaluation of their abilities to demonstrate and apply specific skills necessary for knowledgeable and accurate implementation of PNMPs and Dining Plans. Those conducting the training must be competent in the skills themselves as well as with regard to teaching the skills and completing the check-offs to establish competency. **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.** See above. **Standard: All foundational trainings are updated annually.** Annual refresher courses were currently being developed for existing direct support staff. The monitoring team expects to see significant changes in this area in subsequent reviews. At the time of this review only the lifting portion of the training was conducted as a block refresher course. **Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel.** Tools and checklists used to establish competency and documentation for staff trained to implement PNMPs and Dining Plans were submitted. This consisted of training rosters	Noncompliance

#	Provision	Assessment of Status	Compliance
		signed by participants. A description of the knowledge or skill trained was documented on the roster which appeared to imply competency, though this was not clearly stated and instead most likely only required passive listening or a verbal response rather than a skills-based competency established via demonstration. **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.** Training was not consistently effective as evidenced by the implementation errors noted by the monitoring team and described above. The current system of monitoring had recently implemented a system of targeted review of individuals at highest risk at an individually prescribed frequency to ensure appropriate implementation of supports designed to mitigate PNM risks. **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 was conducted by therapists and PNMPCs. Competency had not been clearly established via this system to date. There was a new system in which the PNMPCs followed up with staff after completion of the NEO training to conduct competency check offs.	
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 formalized policy related to the process of PNM monitoring (lifting, transfers, positioning, mealtime, and communication), though a very limited written procedure had been developed. The frequency of monitoring the specific areas or based on individual risk levels was not outlined. There was no formalized curriculum for training the PNMPCs. Validation of PNMPCs was conducted using the same tool used for monitoring. The licensed clinician and the PNMPC completed the tool simultaneously and discussed the results. A database developed to track PNM monitoring should also track the completion of validation checks with the PNMPCs, as well as the findings of those checks. **Standard: Monitoring covers staff providing care in all aspects in which the person**	Noncompliance

#	Provision	Assessment of Status	Compliance
		is determined to be at an increased risk (all PNM activities). A monitoring form had been developed to address implementation of the PNMP, mealtime, lifting and transfers, use of AAC devices and wheelchair and bed positioning. Though listed on the form, and though there had been implementation of a tracking database, there was no mechanism to ensure that monitoring occurred during bathing, medication administration, or oral care at a prescribed frequency. There were 434 completed PNMP Monitoring Forms completed in the last three months for the 14 of the 15 individuals included in the sample selected by the monitoring team submitted for review. There was no evidence of monitoring in any area for Individual #490. Others were completed as follows: Individual #151 (57), Individual #72 (26), Individual #266 (39), Individual #524 (55), Individual #197 (39), Individual #518 (22), Individual #99 (5), Individual #588 (75), Individual #474 (42), Individual #257 (24), Individual #542 (21), Individual #391 (12), Individual #304 (4), and Individual #494 (10). These had been completed by the PNMPCs in July 2011 (162), August 2011 (184), and September (86) 2011, to date. Two forms were undated. Monitoring was to occur across meals, mobility activities, transfers, communication, oral hygiene, medication administration, positioning, adaptive equipment, behavior and bathing. The PNMP Monitoring Forms as submitted were completed on second shift (46%) and first shift (43%). The others had no shift designated. This represented an even distribution accomplished by scheduling the PNMPCs across shifts. A greater variety of activities was noted, though there was no established mechanism to ensure that these were covered consistently for each individual. The distribution of the 435 complete forms was as follows: • Medication Administration: 39 (9%) • Mealtime: 78 (18%) • Positioning: 68 (16%) • Transfers: 37 (9%) • Bathing: 16 (4%) • Oral Hygiene: 36 (8%) • Adaptive Equipment: 59 (14%) • Mobility: 43 (10%) • Communication: 40 (9%) • Behavior: 19 (4%) The monitoring schedules continued to be under development with the intent to base frequency on health risk indicators. The distribution reported above was not consistent with this, however. For example, Individual #588 was identified as HIGH risk for falls	

#	Provision	Assessment of Status	Compliance
		only, yet was monitored 75 times across three months. On the other hand, Individual #542 was identified at HIGH risk in three areas, yet was only monitored on 21 occasions during the same period. Individual #151, Individual #72, Individual #524, Individual #197, Individual #518, Individual #588, Individual #474, Individual #257, and Individual #542 were identified at HIGH risk in one or more areas. Further examination of the monitoring results should look at the activities monitored. A database was under construction for aggregate data and to track compliance findings and analyze findings, issues, staff re-training, and problem resolution. 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 team will further evaluate this process in the future. **Standard: All members of the PNM team conduct monitoring.** The PNM Team did not conduct monitoring and the results obtained by the PNMPCs were not reported or reviewed in the PNMT process as only one individual had been assessed to date. **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. The system used to track and trend findings should be available to the PNMT and used in their assessment and follow-up on action plan elements and person-specific outcomes that are measurable, meaningful, and functional for the individual. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** Immediate intervention was to occur if an individual was determined to be at risk of harm. The monitor was to notify the appropriate person, such as the charge, home manager, nurse, or therapist. The forms themselves provided a mechanism to document these actions or to document follow-up, but this was not consistently noted.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop	**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 was introduced in January 2011 and the PSTs	Noncompliance

#	Provision	Assessment of Status	Compliance
	and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	continued to face challenges in order to fully implement this process. Discussions with PST members were conducted with the monitoring team in an attempt to understand where the teams were with this and to hopefully move it along. **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 at least on an annual basis, or more frequently based on PST referrals, findings from scheduled monitoring, or other informal observations. A recently implemented system included Activity Plans for quarterly review of specific aspects of PNMPs such as orthotics or wheelchairs for some individuals. The intent was to review fit, function and effectiveness of these specific supports. In the case that an individual participated in direct therapy, progress notes were written, with monthly notes intended to justify continuing or discontinuing the plan. As the goals were not generally measurable, documentation of progress was typically only anecdotal, rather than data based. The system continued to need to be more fully developed and refined so as to ensure assessment of the effectiveness of the plans on a regular basis, in addition to the PNMP and dining plan monitoring conducted by the PNMPCs.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**Standard: All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.** There were 33 (8%) individuals who were enterally nourished. There were six of these individuals who were listed with pneumonia in the last year. One, Individual #61, also received some level of oral intake. There were approximately 10 (3%) individuals with pneumonia in the last 12 months. There were approximately 10 (3%) individuals listed with pneumonia in the last six months. Six of these were diagnosed with aspiration pneumonia. There were 11 (3%) individuals listed at HIGH risk for aspiration. Of those with aspiration pneumonia, only two (Individual #435 and Individual #151) were identified at HIGH risk and five others were listed at MEDIUM risk for aspiration. Individual #588 and Individual #131 each had an occurrence of aspiration pneumonia but were not considered at risk for this significant issue. There were 11 individuals listed at HIGH risk for aspiration and 82 at MEDIUM risk. Each of these individuals were to receive an annual Aspiration Pneumonia/Enteral Nutrition Evaluation and were submitted for 15 individuals. None of these were completed as submitted and none appeared to have been completed by the PST, but rather by a nurse only. Each had an original date in January 2011, with a review date in August 2011. None of the evaluations proposed an action plan to address identified issues. The assessments documented the current interventions. There was no analysis of	Noncompliance

#	Provision	Assessment of Status	Compliance
		findings, recommendations, or action plans and, as such, the evaluation was not satisfactorily complete. Measurable outcomes were provided in a few cases, primarily that the individual would not experience aspiration or pneumonia but without careful examination of the current plan and its effectiveness toward that end. The monitoring team expects significant and timely progress with these assessments prior to the next review. **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 in the selected sample had been provided a PNMP and Dining Plan that included the same elements described above. **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 formal protocol outlined for this process. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** As stated above, assessments were reviewed and were found to be unsatisfactory. MSSLC will require extensive modeling and coaching to ensure proper implementation of this process. **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. An increase in nutritional staff is certainly indicated. The dedicated PNMT dietitian was reportedly planning to step down from the team (O1).

2. Ensure that the PNMT functions as an assessment team that may include collaborative interaction and observation rather than merely a meeting forum to conduct record review and history. Evaluations must be based on new data or information in order to yield a new

perspective to address specific issues that drove the referral to the team (O1).

3. Identify issues that require tracking relative to individuals evaluated by the PNMT, establish the baseline, gather new data over a prescribed period of time, then review the findings as a team in order to analyze the relevance to a problem or as evidence of a solution (O2).

4. Increase the time available for NEO training related to PNM and ensure that refresher courses are developed to address areas other than just lifting (O5).

5. 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. Verbal responses do not suffice in the case that the staff need to perform a specific skill (O5).

6. The establishment of a more interdepartmental/interdisciplinary implementation of PNMPs and Dining Plans is indicated as well as to 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 (O6-O7).

7. Use a collaborative approach to assist the PSTs for improved activity analysis in the development of SPOs for teaching individuals to slow down or take smaller bites. Integrate strategies and prompts like taking a drink, using a napkin, or putting the utensil down for individuals who do not respond to verbal cues. Provide inservice training to staff regarding the appropriate use of physical prompts during meals to redirect (O4).

8. Consider a system of drills for modeling and coaching with staff, perhaps a "flavor of the week" approach. Selection of a particular theme with a focus of training, coaching and review would heighten staff awareness of these concerns and would likely yield overall improvements (O7-O8).

9. Consider more immediate development of a curriculum for training PNMPCs (O7-O8).

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 MSSLC Organizational Chart o Individuals Served- Alpha o Admissions list o Budgeted, Filled and Unfilled Positions by Job Code (6/30/11) o OT/PT Staff list o OT/PT Continuing Education documentation o Section P Presentation Book and POI o Settlement Agreement Cross-Reference with ICF-MR Standards Section P-Physical and Occupational Therapy o Settlement Agreement Section P: OT/PT Audit forms submitted o Individuals receiving direct OT/PT o OT/PT Assessments Data Base (8/23/11) o OT/PT Screening Instructions o OT/PT Evaluation Instructions o Habilitation Therapies spreadsheet o Consultation Data Base o MAP (Multi-Sensory Adaptive Program) proposal o List of hospitalizations/ER visits o Wheelchair Clinic documentation templates o PNMP Monitoring form template o Completed PNMP Monitoring Forms submitted o Completed Validation monitoring forms submitted o NEO training curriculum for PNM o List of Risk Levels for Choking, Falls, Skin Integrity, GERD, Constipation, Osteoporosis, Aspiration, Respiratory (Low, Medium, High) o Pneumonia Diagnosis o Falls o Individuals Taking Pain Medications o List of individuals with enteral nutrition o Pressure Wounds from July 2010 to August 2011 o Fractures o Individuals who were non-ambulatory or require assisted ambulation o People Who Use Wheelchairs for Mobility Only o People Who Use Wheelchairs for Positioning and Mobility o Orthotics Data Base o List of individuals who receive enteral nutrition

	o List of individuals using Ambulation Assistive Devices o PNMPs submitted o Wheelchair Data Base, PNM Wheelchair Clinic Assessments for: • Individual #151, Individual #226, Individual #38, Individual #557, Individual #79, Individual #296 o Incident Reports, PSPAs and follow-up documentation for: • Individual #40 and Individual #322, and Individual #452 o OT/PT Evaluations for: • Individual #261, Individual #268, Individual #437, Individual #324, Individual #207, Individual #483, Individual #390, Individual #62, Individual #598, Individual #305, Individual #425, Individual #362, Individual #505, Individual #264, Individual #511, Individual #503, Individual #167, Individual #452, Individual #302, Individual #272, Individual #44, Individual #128, Individual #206, Individual #457, Individual #340, Individual #176, Individual #119, Individual #39, Individual #276, Individual #339, Individual #101, Individual #371, and Individual #254. o SPOs, PSPs, PSPAs, Assessments and related documentation for: • Individual #101, Individual #483, Individual #131, Individual #381, Individual #225, Individual #454, Individual #503, Individual #35, Individual #151, Individual #557, and Individual #188. o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QMRP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #542, Individual #72, Individual #490, Individual #474, Individual #304, Individual #518, Individual #197, Individual #588, Individual #257, Individual #524, Individual #391, Individual #99, Individual #494, Individual #151, and Individual #266. o PNMP section in Individual Notebooks for the following: • Individual #542, Individual #72, Individual #490, Individual #474, Individual #304, Individual #518, Individual #197, Individual #588, Individual #257, Individual #524, Individual #391, Individual #99, Individual #494, Individual #151, and Individual #266. o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #542, Individual #72, Individual #490, Individual #474, Individual #304, Individual #518, Individual #197, Individual #588, Individual #257, Individual #524, Individual #391, Individual #99, Individual #494, Individual #151, and Individual #266.

	Interviews and Meetings Held: o Brandie Howell, OTR, Habilitation Therapies Director o OTs and PTs, PTAs and COTAs o PNMP Coordinators o Various supervisors and direct support staff Observations Conducted: o Living areas o Dining rooms o Day Programs o Work areas
	Facility Self-Assessment: MSSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Habilitation Director review the Presentation Book onsite and a copy was submitted for review. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements pertaining to a variety of tasks completed related to each of the items of this provision. Also, there was no mechanism to determine how the facility had determined noncompliance with each item in this provision. A blank Settlement Agreement Cross-Reference with ICF-MR Standards Section P-Communication self-audit tool and Guidelines were included in the Presentation Book, and completed audits for 30 individuals (six submitted did not have names) were submitted, from October 2010 through May 2011. Compilation Scores sheets were submitted for June 2011, July 2011, and August 2011 for 19 individuals. It was not clear how the sample was identified for these audits. It did not appear that the audits were used to self-rate or determine substantial compliance. A list of nine Action Steps was included in the POI, related to P2, P3, and P4 only. These actions were not all particularly pertinent to the provision and did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. Eight of the nine action steps were listed as completed. Start dates and projected completion dates were listed, but not actual dates of completion. The first action step listed was identified as, in process, with a completion date of 1/31/12 (Develop an employee manual). This approach appeared to merely document completion of tasks rather than to serve as a clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be short-term, stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. The monitoring team concurs with MSSLC's self-assessment of noncompliance for each of the items in provision P.

	Summary of Monitor's Assessment: Staffing levels had remained stable since the previous review. Most of the contract therapists had extended the length of their commitment to MSSLC. It will be an ongoing challenge, however, to retain staff to ensure consistency of service delivery. The assessment process observed during this review had significantly improved. The report content had also improved, though there was no analysis of findings to establish a rationale for the supports and services provided or to justify why direct supports were not indicated. The health risks identified by the PST were not identified or addressed in any way. Information contained within the OT/PT assessment report should contribute to the team discussion to determine risk levels. Risk levels identified by the collective PST should then drive the supports and interventions via the PNMP and other more direct services. In addition, there was no evidence that pertinent health and medical concerns were considered because there was no analysis of findings or documentation of clinical reasoning. A discussion of health risk issues with a description of functional limitations, skill abilities, and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs, are essential elements to an appropriate clinical assessment. The OT and PT clinicians conducted their annual assessments together and in some cases the SLPs participated in the assessment process as well. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and to review other supports and services. The assessment observed during this onsite review was a good example of this. Clinicians will need to refine how they elicit information so they do not interfere with key elements. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, extremities not adequately supported, or the pelvis not well back into the seat of the wheelchair. No one was observed being repositioned prior to their meal, and a number of individuals were not appropriately aligned or supported. Transfers completed by staff were not properly done. Attention to personal body mechanics used by staff also continued to need improvement. The staff were not confident in their responses to the monitoring team's questions and appeared to be unsure of why they were doing what they were doing in relationship to the PNMP. Ongoing coaching and drills with staff related to risks and the rationale for interventions and supports were indicated to ensure that they were consistently able to discuss the rationale behind recommended interventions and to recognize their role in management of health risk issues.

#	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.** Brandie Howell, OTR, continued as the department Director and chairperson of the PNMT. Current staffing was as follows: one facility-employed physical therapist who also served as the Assistant Director and PT on the PNMT (Sandra Opersteny, PT), four other full-time PTs and two PT Assistants, five full-time OTs (Doris Ricketts, OTR), and three OT Assistants. Christopher Ross was identified as a dedicated PNMT member. Pamela Harlan served as the PNMPC Supervisor, supervising twelve PNMPCs. There was one OT and one PT technician. The clinicians were assigned by teams serving specific homes/units. Martin had two therapy teams, Barnett and Whiterock shared a team, and Shamrock and Longhorn shared a therapy team. Continuing education documented for these clinicians included a program related to pressure ulcer management attended by 11 of the 15 professional clinicians. Several participated in web-based courses on various topics. Three clinicians attended a three-day course, Wheelchair Seating for Postural Control. The increase in continuing education activities at MSSLC was noteworthy and an improvement since the time of the last review. Fabrication and maintenance of seating systems and other assistive technology continued to be conducted with onsite technicians. Harvey Evans, OTR, OTD, served as the lead clinician for the wheelchair seating clinics though the primary clinicians for individuals fully participated in the assessment process. Karen Fleming, COTA served as the assistant for the wheelchair clinic. By report, 60% of the existing wheelchairs had been reviewed with modifications completed. A system of quarterly monitoring had been developed via Activity Plans and these were to be incorporated into the PSP. It was good to see that these reviews were occurring. Based on the current census of 391 and a total of 278 PNMPs submitted, the monitoring team presumed that approximately 71% of the individuals living at MSSLC were identified as requiring PNM supports. As currently staffed, the caseloads were 93 for the each PT and each OT. The PT and OT Assistants were not licensed to conduct assessments or develop intervention plans; they required supervision by the PT or OT, respectively. They were able to gather specific data for assessments, provide interventions, conduct staff training, conduct monitoring, and engage in other responsibilities. The contract therapists were much needed additions to the department. The monitoring team hopes they can be retained beyond the term of their contracts to ensure consistency of supports and services. Clinicians were responsible for the annual assessments or updates, providing supports	Noncompliance

#	Provision	Assessment of Status	Compliance
		and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseloads, with additional supports available from the therapy assistant or technicians. Annual assessments or updates were completed by OT and PT, collaboratively. Some of those who did not have established PNM needs required occasional supports to address acute injuries or to address more chronic conditions associated with aging. Many others would likely benefit from skill acquisition/enhancement programs related to movement, mobility, fine motor skills, and independence. OT/PT assessments were submitted for 15 of 15 individuals included in the sample selected by the monitoring team. Of those submitted, six were not current within the last 12 months (Individual #257, Individual #266, Individual #304, Individual #490, and Individual #197). Of the remaining nine assessments, four were identified as a Comprehensive Evaluation and five were identified as a Baseline Update Assessment. Each was current in the last 12 months. Additionally, most current assessment samples from each therapist (five each) were also requested and assessments for 21 individuals were submitted. These consisted of two OT/PT Comprehensive Evaluations, 16 Baseline Update assessments, and three Baseline Assessments. All were current within the last 12 months. The total number of assessments included for review was 30. At least 21 of the 30 (70%) individuals were identified as having concerns related to movement, mobility, range of motion, limitations in levels of independence, and/or regression of functional skills. Most of the recommendations were for a variety of indirect services via the PNMP, the provision of assistive equipment, and/or orthotics, other consults, and dining supports. A number of individuals were recommended for Activity Plans to monitor specific aspects of their PNMP. Some examples included Individual #339 related to use of a plate guard, Individual #391 related to orthopedic shoes and insoles, and Individual #272 related to the care and fit of her wheelchair. None of the assessments provided a rationale for any of the recommendations outlined via a comprehensive clinical analysis of objective data documented in the reports. The interval for reassessment was specified for each of the assessments considered current in the last 12 months, to occur at the annual PSP though this appeared to be regardless of supports provided. Per the documentation submitted, 11 individuals received direct PT services with 18 participating in activities to maintain ambulation skills or range of motion. Two individuals were provided direct OT with two others participating in activities to maintain range of motion.	

#	Provision	Assessment of Status	Compliance
		Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission. Assessments were completed rather than screenings. Most of the assessments were completed by both OT and PT and in some cases the SLP. Twenty-two individuals had been admitted since the previous review. Sample assessments were requested and 10 were submitted. Each had original, undated signatures rather than copies of the original documents. Per the date of the assessment, nine of 10 were completed within 30 days of admission (Individual #261's was more than 30 days). **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** While the Settlement Agreement indicated that assessment should occur within 30 days of the identified need, this standard is not acceptable when there are urgent issues with potential for further injury or health and safety risks. In the case of Individual #72, he had experienced a fracture of the left humerus. A request for OT assessment had been submitted on 12/17/10 and the assessment was documented as completed on 12/22/10. This was a specific consult only rather than a comprehensive OT/PT assessment conducted due to a significant change in status for Individual #72. **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 this standard, at least 278 individuals at MSSLC should receive a minimum of a comprehensive assessment every three years with interim annual updates (because each of these individuals was identified with PNM needs, that is, he or she had a PNMP). As described above, four of the individuals included in the sample (of 15) had received a comprehensive or baseline assessment within the last 12 months (Individual #151, Individual #99, Individual #474, and Individual #72). Several individuals had received a comprehensive assessment in 2010 but there was no evidence of an update within 12 months (Individual #304, Individual #197, and Individual #266). Individual #494 was provided a baseline assessment on 8/17/10 with a subsequent update current within the last 12months and Individual #518 received a baseline assessment on 1/29/10 with an update on 1/21/11. However, more current updates were indicated and had not been provided. Though the updates for Individual #391, Individual #524, and Individual #588 referenced a comprehensive or baseline assessment, these were not in the individual records. These updates were relatively comprehensive and would be considered a stand-alone evaluation, however, in some cases, the assessment stated that the individual's status was simply unchanged since the baseline or comprehensive assessment (e.g.,	

#	Provision	Assessment of Status	Compliance
		Individual #302). This was only acceptable when the previous assessment was also available. Otherwise the update was meaningless for use by the PST. In the case that an update is used, the original comprehensive assessment should remain in the individual record until a new comprehensive is completed. The assessment process observed during this review had significantly improved (Individual #390). The report content had also improved, though there was no analysis of findings to establish a rationale for the supports and services provided or to justify why direct supports were not indicated. Further, the health risks identified by the PST were not identified or addressed in any way. Information contained within the OT/PT assessment report should contribute to the team discussion to determine risk levels. Risk levels identified by the collective PST should then drive the supports and interventions via the PNMP and other more direct services. Other issues noted in the assessments included: • Functional skill performance was outlined more consistently across the domains included in the assessment. • A tremendous amount of data were presented in the evaluations, such as previous consults and diagnostics (though none of this was considered in an analysis of findings). • The clinical reasoning used by the clinician to guide the development of an intervention plan was not stated in the reports. • Even though the assessments more consistently provided functional examples of systems level findings (e.g., range of motion, strength, muscle tone), this information was not consistently utilized to guide intervention. • There was no assessment as to the effectiveness of the interventions/supports. • There was no consistent 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. • The focus of recommendations continued to be primarily on the provision of the PNMP rather than skill acquisition strategies. As described in Provision O above, there were a number of individuals with health and health risk concerns that would likely benefit from OT and PT supports and services. As the PSP and Health Risk Assessment processes are refined over the next year, they will likely further impact the content, analysis, and recommendations in the OT/PT assessments over the next year.	

#	Provision	Assessment of Status	Compliance
		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)** As stated above, the assessments generally addressed range of motion and movement skills, such as transfers and ambulation. Other functional skills were now more consistently addressed, particularly in the area of fine motor skills and activities of daily living, though improvements were still needed in this area. For example, there was usually no discussion of release, but rather general statements as to reach and grasp only (Individual #391). In most cases, these were described in general statements rather than in the context of functional activities. There was, unfortunately, little consideration for the potential for learning new skills via training objectives. **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.** Consults by OT or PT were completed in response to referrals or for a change in status but a comprehensive OT/PT assessment was not conducted outside of the annual PSP process for any of the individuals for whom assessments were submitted. **Standard: Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment.** The assessments did not typically recommend further specialized evaluations for wheelchair seating or for other issues because these were typically assessed at the time of the comprehensive evaluation. Separate wheelchair assessments were generated related to that process in addition to the OT/PT assessment. The annual assessments typically provided a brief description of the seating system components for individuals with a rationale for their selection in some cases, but did not consistently address whether the system was appropriate as to fit, function, and condition. The new seating assessment process had significantly improved since the previous review and included a very thorough and a comprehensive written report was provided (e.g., Individual #151). **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.**	

#	Provision	Assessment of Status	Compliance
		Health risk indicators identified by the PST were not included in the assessment reports. In addition, there was no evidence that pertinent health and medical concerns were considered because there was no analysis of findings or documentation of clinical reasoning. A discussion of health risk issues with a description of functional limitations, skill abilities, and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs, are essential elements to an appropriate clinical assessment. The risks addressed in the OT/PT assessment should be consistent with those established by the PST. Though if at any time there was evidence that the risk rating should be modified due to a change in status, the PST should meet to review this. The PNMP should be modified as needed to reflect these changes. This should also be reflected in the OT/PT assessments. Information contained within the OT/PT report should contribute to the team discussion to determine risk levels. If there was a rationale for a difference in these ratings identified in the annual assessment, this should be stated in the report for PST consideration. Risk levels identified by the collective PST should then in turn drive the supports and interventions via the PNMP and other more direct services provided by the therapists to assist in addressing those concerns. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** The OT and PT clinicians conducted their annual assessments together and, in some cases, the SLPs participated in the assessment process as well. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and to review other supports and services, as indicated. The assessment observed during this onsite review was a good example of this. Clinicians will need to refine how they elicit information so they do not interfere with key elements. For example, the speech therapist was interested to see if Individual #390 would look for, or request, a sensory ball that had been removed from the immediate area. The PT picked up the ball to do another activity with it. Therapists should share the lead for directing the evaluation activities and communicate clearly what outcomes they typically looked for during these sessions. The clinicians should also collaborate to schedule observation periods in a variety of settings throughout the individual's day. These sessions should be for observation with minimal interaction by the clinicians in order to get an accurate picture of routine activities and how the individual participates, responds and interacts. This better allows opportunities to identify potentials and needs related to skill acquisition across all domains.	

#	Provision	Assessment of Status	Compliance
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 and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**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.** Approximately 278 individuals at MSSLC were provided a PNMP (based on the number submitted for review), and as such, had been identified with PNM needs. These plans were reviewed by the therapy clinicians as an aspect of the annual assessment; there was no other more frequent routine review. A relatively new system had been implemented to include the development of Activity Plans to provide quarterly monitoring by the therapists and this was reflected in a number of the OT/PT assessments submitted. It was not clear, though, why certain aspects of the PNMPs for some individuals were selected for monitoring in this manner, rather than a review of the entire plan for each individual determined by risk level. Implementation of the plans was also monitored by the PNMPCs, though this addressed implementation only. As non-licensed clinicians, these staff were not qualified to make judgments as to efficacy of the plans. There was a system of asterisks to alert staff to specific changes in the plans. The PNMPs appeared to be updated in a timely manner relative to the annual PSPs but response to requested assessment and intervention was not consistently within this time frame. Some examples included: • An evaluation of Individual #483 was requested on 3/29/11. The OT assessment was initiated on 4/29/11 and carried out through 5/9/11. Recommendations included a weighted blanket for sleep and a weighted vest for activities requiring focus and attending. A program plan was dated 6/27/11, nearly three months after the initial referral. • Individual #101 was seen for PT treatment related to back pain, lower extremity strengthening, and general body conditioning. A program plan was developed for implementation on 6/10/11. The short-term objectives were not measurable with sufficient performance criteria and timeframes identified. He was seen through 8/26/11 and discharged at that time. There was no report of his progress or status and, as such, there was insufficient rationale to discontinue intervention at that time. • There was a PSP Addendum for Individual #381 on 8/4/11 documenting his need for participation in a formal exercise program, per PT recommendation. There was no further identification of measurable training objectives or data. The only PT program was for quarterly monitoring of his insoles/calluses. The identification of this problem was on 5/24/11 in Orthotic Clinic. This program of monitoring was not initiated until 7/28/11, two months later. There was no baseline established with the initiation of this plan. • A PSP addendum was submitted for Individual #225 to establish his participation in PT related to pain in his right leg. There was no evidence of a PT assessment documented. The PSP indicated that he would begin therapy on 7/25/22. There	Noncompliance

#	Provision	Assessment of Status	Compliance
		was no evidence that this plan was implemented within 30 days. There were no measurable objectives established other than "no complaint of pain for right knee." • The OT/PT Assessment for Individual #131 was dated 3/24/11. She was described with pitting edema in both lower extremities for which knee high compression socks were to be worn during her waking hours. On 6/13/11, a PSPA was held to discuss a PT consultation on 6/9/11. Again it was recommended that she would benefit from wearing compression socks and the addition of ankle pumps for five minutes daily and a 10-minute massage. A program plan was implemented on 6/13/11, however, there was no plan for the exercises to be completed by direct support staff, rather only the monitoring by PT. It was reported that staff completed the exercises, but there was no mention of whether they effectively addressed the identified problem of edema. Interventions were generally referral-based only and were limited with regard to minimizing regression and enhancing skills. Though OT interventions were reported to be in place at the time of this review for four individuals, documentation for only one (Individual #483) was submitted. Consultations were not consistently completed in a timely manner. For example, a referral had been made for an exercise program assessment for Individual #518 on 3/29/11. This was not completed until 6/15/11 over two and a half months later. The recently developed tracking log will assist the department in following each referral through to completion. A number of Activity Plans for quarterly monitoring had been developed and these were submitted for review. A number of individuals were identified with limitations in fine motor and activities of daily living skills, though interventions to address these were not provided to an individual at MSSLC. Specific objectives described above to outline direct therapy and interventions were not integrated into the PSP as training objectives (SPOs). Documentation of these supports were included in the plans and file in the Habilitation Therapy tab of the individual record rather than in the Integrated Progress Notes or as an aspect of the PSP. **Standard: Within 30 days of development of the plan, it was implemented.** As described above, implementation of the plan for Individual #483 occurred within 30 days, but that was nearly three months after the initial referral. Documentation was noted for each intervention with a monthly progress report written. While the summary identified progress, it did not specifically discuss progress on the measurable objectives outlined in the plan. Additional intervention was described by the COTA during individual treatment sessions (for example on 9/13/11, 9/16/11, 9/20/11, and 9/22/11). The rationale for these interventions and functional, measurable outcomes and objectives	

#	Provision	Assessment of Status	Compliance
		were not outlined in the assessment or plan. Though interventions provided beyond the PNMPs were limited and not integrated into the PSP, specific PT interventions were consistently documented based on review of the information submitted. Though assessments and other documentation was requested for all individuals who participated in OT or PT treatment (34 per the list submitted), submissions were for 12 individuals, some of whom were not included on the list of interventions submitted. 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. Likewise, continuing or discontinuing an intervention required an adequate and appropriate rationale and justification. All therapy-related SPOs should be an action step in the PSP. They should also be subject to routine PST review with reported data related to progress. A new database had been recently established to track referrals and consults. There was insufficient data available as yet at the time of this review, however. **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 any of the assessment reports to provide a rationale for the PNMPs developed for individuals or for other interventions. The clinicians' clinical reasoning process used for the recommendations was not documented in any way. PSP Addendums were not consistently developed to address modifications to PNMPs and other therapy interventions. In the case of Individual #101, he was participating in direct PT at the time of his PSP meeting on 6/22/11. While it was mentioned that he participated in PT, there was no report on his progress and there were no training objectives identified in his annual plan. There was no PSP addendum related to the provision of OT supports as recommended in the OT evaluation on 5/9/11 or 6/17/11. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** The primary support provided was via the PNMPs. PNMPs provided staff instructions or precautions related to assistance and supports for mobility, positioning, and transfers. Additional areas addressed included bathing and skin care, behavior concerns, communication, and precautions. Medication administration and oral hygiene were consistently addressed in the plans. Mealtime instructions included dining equipment but not diet texture or liquid consistency. Assistive equipment was included, as well. Risk levels in specific areas were identified. The focus statements were intended to identify	

#	Provision	Assessment of Status	Compliance
		the justification for the supports outlined in the plan. These were generally disconnected, however. For example, in the case of Individual #592, the focus of his PNMP was to prevent behavioral episodes through communication. The only information included under communication was that he was verbal. There was nothing in the plan that would effectively prevent behavior challenges. In the case of Individual #569, the focus of the PNMP was to promote independence using assistive equipment, though none was listed in the plan. Further, the plan was intended to prevent joint contractures, skin integrity, and facilitate skill acquisition. There was nothing in the plan to address these areas and he was described as independent in all areas. He was identified at low risk for aspiration, choking, skin integrity and osteoporosis with no supports outlined in the PNMP. There was no apparent reason for the plan. PNMPs for the 15 of 15 individuals in the sample selected by the monitoring team were submitted. Each had been updated one or more times in the last 12 months. The plans for Individual #99 and Individual #490 were included in the record document request only. **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 rationale for the specific equipment recommended for use, though the rationale for the wheelchair seating was more consistently noted. There were no pictures related to equipment or positioning submitted with the PNMPs. Photographs provide a valuable source of information to staff about how to use the prescribed equipment and how to appropriately implement plans. Without these visual cues, errors would be likely. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** There were few intervention plans and the rationale for initiation of intervention was not generally clearly established. Documentation was consistent, but did not address progress or status. **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, documentation was noted for each contact/session with monthly progress notes in most cases included on the program	

#	Provision	Assessment of Status	Compliance
		plans. These were filed in the Habilitation Therapies section of the individual record without documentation in the Integrated Progress Notes. In some cases, the therapists reported documenting that an assessment had taken place in the IPNs, but not as consistently related to routine interventions. The documentation reviewed related to OT/PT intervention did not provide a comparative analysis of progress from month to month, however. Reviews of the PNMP were conducted annually, upon referral, or based on the findings of monitoring. There was evidence of the therapists addressing some issues identified through monitoring or referral, yet documentation of follow-up through to resolution was inconsistent. Specific quarterly monitoring by the therapists was established via Activity Plans. As stated above, it was not clear why the entire PNMP was not monitored, but rather a specific aspect, and why the schedule of monitoring was selected for some individuals and not others. There was no rationale offered in the assessments or Activity Plans themselves.	
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. There were no pictures provided to illustrate optimal alignment and support for the intended individual and, as such, would not provide adequate visual cues to staff. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, extremities not adequately supported, or the pelvis not well back into the seat of the wheelchair (e.g., Individual #202, Individual #231, Individual #321, Individual #117, Individual #524, and Individual #38). No one was observed being repositioned prior to their meal, and a number of individuals were not appropriately aligned or supported. Transfers completed by staff were not properly done (Individual #60, Individual #328, Individual #285 and Individual #197). Attention to personal body mechanics used by staff also continued to need improvement. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** NEO training related to implementation of the PNMP was offered in approximately one day of training. A written test was required for each aspect of the training, though skills based performance testing was very limited. This lack of competency-based training of foundational skills necessary to the appropriate implementation of the PNMP may contribute to staff weaknesses as well as their limited understanding of the rationale behind the strategies outlined in the PNMP.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual-specific training was also reported to be competency-based. Licensed therapy staff as well as PNMPCs provided training for home supervisors, home managers, and other staff. **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 and therapists. There was no method to track if this covered all staff who were responsible for implementation of PNMPs. Approximately 450 monitoring sheets of the were reviewed. Of these, only 22 had a "no" response in relation to one or more indicators on the monitoring form. Typically, there was a notation that re-training was provided at the time of the monitoring. In no case, was additional follow-up identified as necessary. There was no evidence that the training was competency-based. There was no system to review and analyze the collective findings of the PNMPCs. **Standard: Staff verbalizes rationale for interventions.** The staff were not confident in their responses to the monitoring team's questions and appeared to be unsure of why they were doing what they were doing in relationship to the PNMP. For example, staff were generally not able to answer questions, such as why an individual needed honey thick liquids, why a glass was only partially filled, or why a particular orthotic was required. The rationale for interventions and supports was stated in the focus statements of the PNMP, but in many cases, these were general in nature rather than specific to strategies outlined in the plan. In some cases, they did not reflect important aspects of an individual's needs as described above. This is an important aspect of staff training. Ongoing coaching and drills with staff related to risks and the rationale for interventions and supports were indicated to ensure that they were able to discuss the rationale behind interventions and to recognize their role in management of health risk issues.	
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.** As stated above, adaptive equipment was reviewed on at least an annual basis at the time of the PSP assessments, in addition to review per referral by the PST to address fit and function. This was conducted by the licensed therapy clinicians. A recently implemented system of monitoring of specific aspects of the PNMPs had been established for the clinicians to proactively review equipment for fit and function on a quarterly schedule.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	The rationale for who and why this was provided was not clearly stated in the assessments. The AT workshop technicians completed all maintenance and repairs as identified via monitoring system or as reported by direct support staff. Work orders were tracked in a log/database. Assessments were conducted as needed for new seating systems or for modifications to existing systems. Specific mat evaluations and assistive technology assessments documented this process. The assessment conducted during the week of this review reflected an improved assessment process more consistent with current generally accepted standards of practice. There were concerns, however, with the final products provided and all will require further modifications and refinement to appropriately meet individual needs (Individual #44, Individual #446, Individual #60, Individual #38 and Individual #557). The monitoring team will need to observe this during future reviews. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** PMNP Monitoring forms were used to conduct monitoring by the PNMPCs and therapists. This form addressed availability of plans, use of proper lifting and transfer techniques, appropriate positioning, and condition of equipment. The individual and direct support staff were identified. The monitor was to document corrective actions taken or required. Individuals considered to be at high risk were monitored two times monthly, while others were monitored monthly or every two months, based on a schedule developed. The PNMPCs worked across all shifts, so monitoring occurred throughout all the daily activities. Documentation of findings was generally on the monitoring form itself, though PNMPCs also documented in the Integrated Progress Notes or the observation log on the home. Greater consistency was necessary. Completed monitoring sheets for the last month were requested. There were hundreds of completed PNMP monitoring sheets submitted that were completed in August 2011 by the PNMPCs. This monitoring focused on PNMP implementation and condition of equipment because the PNMPCs were not qualified to make determinations as to the effectiveness of the plans. The development of Activity Plans had recently been implemented to ensure at least quarterly review by the therapy clinicians with regard to effectiveness orthotics, wheelchairs and other supports. As described above, there was no rationale for why this was provided to some individuals and not to others, or why the entire PNMP was not reviewed at quarterly intervals. There was no system to track the findings from any monitoring for use in decision making about staff training needs or drills. **Standard: For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the**	

#	Provision	Assessment of Status	Compliance
		individuals. This includes pulled and relief staff. This was reported to be true by therapy clinicians, however, there was no system to assure that those who were most at risk were assisted by competent and well-trained direct support staff only. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** There was no evidence of follow-up of any issues identified during monitoring by the PNMPCs. In most cases, however, the form indicated that staff re-training had been completed. Anecdotally ,the PNMPC supervisor described cases that follow-up was completed through to resolution, but examples were not noted in the monitoring sheets submitted for review. By report, these were documented in the IPNs. **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, though procedures were in development, as described above. Validation of PNMPCs was conducted using the same tool used for monitoring. The licensed clinician and the PNMPC completed the tool simultaneously and discussed the results. At that time, additional training was provided as well as follow-up as indicated. These were scheduled, but it was not clear how consistently this was conducted. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** Interventions by the PT were reviewed on a monthly basis with documentation in a progress note, however the objectives were not consistently written with appropriate performance criteria. Some of these would be met if the individual completed the behavior one time. **Standard: Data collection method is validated by the program's author(s).** There were no SPOs submitted for review that required data collection by direct support staff or validation of implementation and documentation this time.	

Recommendations:

1. Consider a reference to the baseline/comprehensive assessment and updates in subsequent updates. In other words, the therapist should clearly cite the date of the previous assessment in the current one. It may make sense to maintain the comprehensive assessment with the subsequent updates in the active record until a new comprehensive was completed. Clear statements as to when the next assessment or update was to be completed should be included in the recommendations (P1).

2. Consider the integration of risk information in NEO training as well as more hands-on practice for skills based competencies (P2).

3. There is a significant need to develop programs to address increasing or expanding functional skills. Formal programming is indicated for a number of individuals. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (P2).

4. Integrate direct and indirect supports into the PSP through the development of SPOs that include 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 are used to justify initiation, continuation, and/or termination of interventions (P2).

5. Consider the strategy of observation rounds with professional staff, technicians and PNMPCs to conduct drills for additional training for PNMPCs and to assist staff in recognizing when realignment is indicated (P3-P4).

6. Establish a formal curriculum and competencies for training the PNMPCs (P4).

7. Review the methods used to analyze databases to ensure accuracy of calculations of compliance (P4).

8. Review the existing OT/PT assessment format to address summary/analysis. As currently written these were not consistently sufficient to establish the rationale for the recommendations. The development of a framework that included more specific guidelines for therapists in their treatment of the analysis of findings and justification for supports and interventions in the PNM clinic and the written reports would be useful, particularly with the addition of new therapy clinicians. 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, services and interventions were indicated. These should then be listed as recommendations (P1).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o MSSLC Policy and Procedure: Facility Operational Dental Services Policy, 5/1/11 o MSSLC Organizational Charts o MSSLC POI for Section Q o Presentation Book, Section Q o Procedure for Oral Suction toothbrush o Attendance Tracking Records o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Dental records for the individuals listed in Section L o Desensitization plans for the following individuals: • Individual #456, Individual #500, Individual #196, Individual #481, Individual #369 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 Brandie Howell, OTR, Habilitation Therapies Director o Meeting with interim facility director, medical director, and dental director Observations Conducted: o Dental Department o Informal interviews with clinic staff
	Facility Self-Assessment: The facility updated the POI on 9/8/11 and determined that it was not in compliance with any of the provision items for Section Q. This assessment was congruent with the findings of the monitoring team. The POI indicated that a 5% sample of records was randomly selected for completion of auditing to determine compliance with the requirements of the Settlement Agreement. Although the POI indicated that compliance was 95% or better from 7/10 – 10/11, the last compliance monitoring entry was dated 2/1/11. There was no information provided relative to the use of these compliance rates in determination of the self-rating of noncompliance.

	The POI did provide regular updates related to the various steps the facility had taken to decrease missed appointments. Furthermore, it provided an action plan that contained 12 action steps that addressed some of the recommendations from the last monitoring visit. This was a positive start in moving towards substantial compliance with the Settlement Agreement. The action steps, however, did not provide enough detail to result in the intended outcomes. As the facility moves forward, it might be helpful to think of the action steps as goals. With the action steps viewed as goals, the facility will need to develop, for each goal, a specific set of detailed objectives. The action steps would be the specific implementation steps needed to achieve the objectives and goals. The self-assessment process will require numerous activities and utilize information from multiple sources and departments. These activities will include auditing of records, completing peer reviews, and generating data on attendance and provision of services and observations.
	Summary of Monitor's Assessment: The dental department made little progress towards substantial compliance with the Settlement Agreement. Moreover, this review was challenged by a lack of key information needed to assist the monitoring team in determining compliance with the Settlement Agreement. This issue was surfaced in the September 2010 review and was more pronounced in the March 2011 review as evidenced by submission of only 17% of the documents requested. For this review, 40% of the items requested were responded to with "none" or not available. Another disconcerting issue was noted in the data that were submitted. The facility continued to report that no oral sedation or chemical restraints were utilized. This was technically correct, as oral sedation was not administered to those receiving treatment in clinic. Data related to oral surgery, however, indicated that numerous individuals were sent to a local medical facility for a variety of procedures, including simple extractions, which involved the use of conscious sedation and general anesthesia. There was no process in place for the Human Rights Committee to review the use of restraints for these off-campus procedures. Collaboration between the medical and dental directors was lacking and this made moving towards compliance even more difficult. This was a disappointing finding since this issue was discussed during the last review and a recommendation was made for the medical director to have more frequent contact with the dental director and provide more support and guidance. The facility lacked a formal process to address the issue of failed appointments and refusals. The POI documented that information on missed appointments and oral hygiene status was sent to the director of home life, each unit director, nurse mangers, and psychology director. The dental director indicated that he did not receive follow-up. Many individuals were brought back to clinic for informal desensitization, but there was no threshold set for referring these individuals for desensitization plans. The result was many individuals who repeatedly refused treatment and sometimes, ultimately, required multiple extractions.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	The dental clinic staff was comprised of a dental director, staff dentist, two registered dental hygienists, and two dental assistants. Dental clinic was conducted five days a week from 8:00 am until 5:00 pm. The new dentist began employment in June 2011. <u>Provision of Services</u> The dental clinic provided basic dental services, including prophylactic treatments, restorative procedures, such as resins and amalgams, and x-rays. Those individuals who required more advanced treatment were referred to the Scott and White dental clinic. Record reviews indicated that those who received dental services and attended clinic received appropriate care and were seen frequently in clinic. Those individuals who refused clinic services or were not able to cooperate very often did not receive the care they needed in a timely manner. Data related to the provision of dental services were collected. Multiple dental clinic attendance tracking spreadsheets were provided. A request was made for the total number of clinics as well as the total number of clinic visits for the various types of services. The total number of visits was provided, but those numbers differed from the data contained in the clinic attendance tracking. The spreadsheet containing data on the types of visits included information related to employee leave, committee meetings, and other items and was, therefore, considered non-useable. <u>Emergency Care</u> Emergency care was available during normal business hours. After business hours, the on-call physician had access to the dental director by phone. Guidance could be provided on treatment and individuals referred to the local emergency department, if necessary. Records related to provision of emergency care indicated that appropriate care was provided. <u>Oral Hygiene</u> 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. Data indicated that 44% of individuals had good oral hygiene, 45% had fair hygiene, and 11% had poor hygiene. There were no prior data for comparison. Oral hygiene instructions were provided to the individuals and staff during clinic visits. All direct care professional were required to complete pre-service training on the provision of oral hygiene. They were also required to complete annual training on the provision of oral hygiene through ilearn. Oral hygiene data were submitted to the home managers, unit administration, habilitation services, nurse managers, PST, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		psychology. Review of PET meeting notes indicated that this information was discussed at daily unit meetings and the PSPs responded by development of plans and objectives. There was evidence in the records that, to some extent, this occurred. The POI also documented that a suction toothbrush program was implemented. The response to the monitoring team's request for a list of individuals receiving this treatment was "none." The dental director referred the monitoring team to the habilitation services director for additional information. The habilitation services director reported having previous experience with the use of suction toothbrushing and the associated clinical outcomes. A written procedure was developed to provide instructions to staff. One individual was receiving this support at the time of the onsite review. Since the support had just recently been implemented, there was no follow-up information on clinical response.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	<u>Policies and Procedures</u> The dental director presented the monitoring team with a local dental policy that was developed based on state issued policy. The policy was dated 9/16/11 and was reported to be a draft. The medical director subsequently informed the monitoring team that the policy had been approved. Since the policy was initially believed to have been in draft form, the dental clinic had had yet to receive training on the policy. <u>Annual Assessments</u> In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months and the date of previous annual assessment was requested. The facility provided a list of individuals. The list contained 190 individuals. • 160 of 165 (97%) individuals completed exams within 365 days of the previous annual exam • 25 of 190 (13%) completed initial exams o 25 of 25 (100%) completed initial exams within 30 days of admission <u>Dental Records</u> Dental records consisted of initial/annual exams, dental progress treatment records and documentation in the integrated progress notes. All records of the dental examination were made in the progress treatment records. Pointer notes were placed in the IPN to share essential information with the PSPs and direct readers to the dental treatment records contained within the active records. The notes were dated, timed, and signed. Some entries were not clearly legible.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Documentation of dental treatment was found in the IPN and in the various treatment records. Reviews of records indicated that many of the individuals living at the facility received a variety of dental services and they were seen frequently. There was also evidence that numerous individuals did not receive treatment, usually due to refusal of services. <u>Failed Appointments</u> As previously discussed, the monitoring team was presented with various sets of data. The attendance tracking sheets provided a list of all individuals seen in clinic. If the column was blank, it indicated the appointment was completed. Failed/missed appointments were categorized as refusals, other, or no staff. The total number of visits was determined by subtracting the number of failed appointments from the total visits listed. These data are presented in the table below.	

Dental Attendance Tracking Data 2011						
	Mar	Apr	May	June	July	August
Total Visits	388	349	316	351	274	372
Total Failed/Missed	79	85	85	62	36	67
Refused	33	32	33	28	12	36
No Staff	7	13	7	6	3	6
Other	39	40	38	28	21	25
Total Completed	309	265	238	289	238	305

The monitoring team's request for a list of interventions for missed appointments such as correspondence to home managers and QMRPs, and PSP minutes that reviewed, assessed, developed, and implemented strategies for refusals were both responded to with "None." The monitoring team discussed these issues with the dental director who reported that he shared information with all of the appropriate staff, but received no feedback or follow-up and, therefore, did not know what corrective actions were taken. Specifically, it was reported that information on missed appointments went to unit administration, the PSTs, and the psychology director for review. The dental director did not make any specific requests regarding assessment for the appropriateness of desensitization because the data was sent to the PSPs and psychology.

<u>Restraints</u>
The facility reported that no chemical restraints or general anesthesia were used by the facility. There were no submissions of information related to sedation and chemical restraint because the response to the monitoring team's request indicated that MSSLC did not use chemical restraints. This turned out to be inaccurate, based on documents reviewed by the monitoring team. Individuals supported by the agency were referred to a local medical facility where conscious sedation and general anesthesia were used to

#	Provision	Assessment of Status	Compliance
		complete dental procedures. These referrals were not necessarily for complicated procedures, but were often due to the individual's inability to cooperate sufficiently to receive treatment in the campus clinic. During the onsite review, the monitoring team requested additional information related to data submitted related to oral surgery. A list of all individuals with off campus dental appointments was provided. This list contained the names of 27 individuals who received dental treatment off campus between March 2011 and August 2011. Twenty seven individuals received treatment off campus: • 10 of 27 individuals (37%) had greater than 10 teeth extracted or "remaining teeth" extracted • 4 of 27 individuals (15%) had wisdom teeth extracted • 5 of 27 individuals (18%) had third molar extractions • 3 of 27 (11%) had 4-5 teeth extracted • 4 of 27 (15%) had 3 or fewer teeth extracted Additionally, the facility staff administered chemical restraints to two individuals in association with dental procedures: Individual #139 received valium 5 mg on 2/17/11 and Individual #2 received valium on 3/30/11. Both individuals were seen in the psychiatry clinic and neither had desensitization plans or benefitted from any type of HRC approval process. The dental director explained, and records verified, that some individuals had frequent appointments in clinic. The goal was to gradually introduce them to the environment. There was some measure of success with this informal approach to desensitization. The problem with the approach, however, was that in those cases where this method failed, there was rarely a request made to the team and/or psychologist for the individual to have a formal assessment to determine if desensitization was appropriate. Although a substantial number of individuals refused dental services, there were only five current desensitization plans, with only one developed since the last monitoring visit. Of the five plans reviewed, four were implemented in 2010. The plan for Individual #456 was implemented on 7/18/11. The plans were individualized to meet the specific needs of the individuals. The current list of HRC approved dental/medical restraints with sedation was requested, but no list was available. During discussion with the dental director, it was pointed out that there was no process that required HRC approval for restraints utilized off campus. In fact, the dental director noted that he was a member of HRC and there was no requirement for desensitization assessment prior to referral off campus, as most of the individuals were in need of immediate treatment. The monitoring team highlighted that	

#	Provision	Assessment of Status	Compliance
		several of the individuals had refused treatment for long periods and were never referred to psychology following failure of informal desensitization. As discussed previously, the dental director informed the monitoring team that no feedback was received relative to the information distributed. The POI provided some information related to the facility's management of failed appointment because it documented several steps taken, such as sharing information with residential staff and home life related to oral hygiene and refusals. The PET minutes also documented some of the efforts on the part of the facility to decrease failed appointments. Comments from the medical director indicated that the efforts were not adequate as it was stated that information was shared, and discussion occurred, but the dental clinic did not know what actions were taken. Subsequent PET minutes noted that the dental director should review the unit meeting minutes. A copy of the Shamrock Unit Meeting Notes, dated 5/26/11, was reviewed. The notes contained a section related to missed dental appointments and refusals. Comments included discussion of problems and/or trends noted. Immediate action taken was none. Follow-up required was none. Individual #564 refused to go to dental clinic due to work. The PSP documented that the individual would attend clinic every six months, but not more often. This agreement was apparently made without input from the dental clinic. The monitoring team met with the facility director, medical director, and dental director to discuss issues related to the use of sedation, desensitization, and failed appointments. The result of the meeting was a plan for the dental director and medical director to increase collaboration and begin work immediately to address the concerns surfaced by the monitoring team. The dental director and medical director both acknowledged commitment to working together on dental services issues in order to move towards compliance with the requirements of the Settlement Agreement.	

Recommendations:

1. The dental director should ensure that all staff are trained on the newly approved dental services policy (Q1).
2. A database should be developed that will allow for collection of data and generation of appropriate reports related to clinic attendance and provision of services (Q1).
3. The facility should move forward with implementation of the suction toothbrushing program for those who are highest risk. Documentation of progress should be provided to the dental director (Q1)
4. The facility needs to track oral hygiene of each individual on a quarterly basis (Q1).

5. Legibility of dental clinic notes should be improved (Q2).

6. The facility should also ensure that the appropriate review by the Human Rights Committee occurs prior to the use of chemical restraints (Q2).

7. The PST should collaborate with the dental clinic to develop and implement strategies to over come barriers to receiving appropriate dental care. This process should be formalized to ensure that it occurs consistently and that all parties are aware of the plan and the desired outcomes. The PST should also evaluate the outcomes linked to the interventions and make changes when there is a failure to respond to interventions (Q2).

8. 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. A formal plan of correction is needed including determination of goals, objections and implementation steps. Progress in this area should be monitored and appropriate changes made if there is a lack of improvement (Q2).

9. 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 (Q2).

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 MSSLC Organization Chart (9/1/11) o Individuals Served- Alphabetical list o Admissions list o Budgeted, Filled and Unfilled Positions (7/31/11) o AAC Services Policy #16 (10/07/09) o Section R Presentation Book and POI o Settlement Agreement Cross-Reference with ICF-MR Standards Section R-Communication Guidelines o Settlement Agreement Section R: Communication Audit forms submitted o Continuing Education documentation submitted o Current list of Speech staff o Augmentative Communication/Assistive Technology Evaluation template o Augmentative and Alternative Communication Profile o Speech Pathology Baseline Assessment template o List of AAC devices at MSSLC o PNMPs submitted o List of Individuals with Behavioral Issues and Severe Language Deficits o List of individuals with PBSPs o Master Plan (8/31/11) and Data Base (8/30/11) o Speech Assessments Data Base (8/23/11) o List of Individuals receiving direct speech therapy o Monitoring Tool templates o PNMP Monitoring Forms completed for the last month related to communication o SPOs, PSPs, PSPAs, Assessments and related documentation for: • Individual #455, Individual #359, Individual #436, and Individual #428. o Communication evaluations and PSPs: • Individual #483, Individual #390, Individual #247, Individual #598, Individual #305, Individual #425, Individual #362, Individual #505, Individual #511, Individual #503, Individual #167, Individual #452, Individual #302, Individual #272, Individual #44, Individual #128, Individual #206, Individual #457, Individual #340, Individual #176, Individual #119, Individual #39, Individual #378, Individual #276, Individual #339, Individual #101, Individual #264, Individual #62, Individual #371, and Individual #254. o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QMRP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries,

	Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #542, Individual #72, Individual #490, Individual #474, Individual #304, Individual #518, Individual #197, Individual #588, Individual #257, Individual #524, Individual #391, Individual #99, Individual #494, Individual #151, and Individual #266. o PNMP section in Individual Notebooks for the following: • Individual #542, Individual #72, Individual #490, Individual #474, Individual #304, Individual #518, Individual #197, Individual #588, Individual #257, Individual #524, Individual #391, Individual #99, Individual #494, Individual #151, and Individual #266. o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #542, Individual #72, Individual #490, Individual #474, Individual #304, Individual #518, Individual #197, Individual #588, Individual #257, Individual #524, Individual #391, Individual #99, Individual #494, Individual #151, and Individual #266. <u>Interviews and Meetings Held</u>: o Brandie Howell, OTR, Habilitation Therapies Director o Speech Language Pathologists o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs o Work areas
	Facility Self-Assessment: MSSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Habilitation Director review the Presentation Book onsite and a copy was submitted for review. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements pertaining to a variety of tasks completed related to each of the Settlement Agreement provisions. Also, there was no mechanism to determine how the facility had determined noncompliance with each element in this provision. A blank Settlement Agreement Cross-Reference with ICF-MR Standards Section R-Communication self-audit tool and Guidelines were included in the Presentation Book, and completed audits for 31 individuals (two submitted did not have names) were submitted, from October 2010 through May 2011. Compilation Scores sheets were submitted for June 2011, July 2011, and August 2011 for 19 individuals. It was not clear how the sample was identified for these audits. It did not appear

	that the audits were used to self-rate substantial compliance. A list of eight Action Steps was included in the POI, related to R1, R3, and R4 only. These actions were not all particularly pertinent to the provision and did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. Six of the eight action steps were listed as completed. Start dates and projected completion dates were listed, but not actual dates of completion. The other two action steps listed were identified as in process with completion dates of 12/31/12 (recruit and retain adequate number of SLPs). This approach appeared to merely document completion of tasks rather than to serve as a clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be short-term, stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. The monitoring team concurs with MSSLC self-assessment of noncompliance for each of the items in provision R.
	Summary of Monitor's Assessment: Per the Presentation Book for section R, all individuals identified as Priority 1 (81 individuals) and Priority 2 (61 individuals) had been provided a comprehensive communication assessment and there were only 28 of 138 individuals identified as Priority 3 who had not yet received an assessment. Assessments were not consistently completed prior to the due date and, in fact, some were completed on the day of, or after, the PSP meeting. There were only 23 individuals with one or more AAC systems, though an additional list included 32 individuals with one or more AAC systems. This represented only 16% (or 23%, depending on the list) of those individuals identified as nonverbal or partially verbal (Priority 1 and 2). It was of concern, however, that very few new systems or objectives had been provided, based on the assessments, especially for those individuals identified as nonverbal or partially verbal. This brought into question the validity of the findings of these assessments (as well as their functionality and usefulness). There were another 120 individuals (85%) with a Communication Dictionary only. This was for staff to interpret communicative efforts by the individual. It did not enhance or augment the individual's communication abilities. Only four individuals received some type of direct communication intervention. Despite this, the clinicians reported that all individuals with potential to benefit from AAC had been evaluated and that each individual's needs had been met. It was of concern that the SLPs were not involved in the development of SPOs for use in day programs and the homes as well as, therapist directed interventions in the form of individual programming or group activities. The assessments varied in the degree to which they were comprehensive.

	The AAC sections of the assessments were very limited and, in many cases, did not reflect thorough review of possible options for assistive technology or skill acquisition programming. The rationale and recommendations did not consistently reflect a careful and thoughtful consideration of AAC systems, skill acquisition potential, and the consideration of learning opportunities designed and directed by the SLPs. Consistent implementation of AAC systems continued to be a concern. Direct support staff did not appear to be knowledgeable regarding communication programs. No communication systems were observed being used. There were no general use devices noted. 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.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**Standard: The facility provided an adequate number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. Training included augmentative and assistive communication.** At the time of the onsite monitoring review, there were five full time SLPs and two speech assistants. Two were facility-employed and three were contracted. The two SLPAs were state employees. There was one audiologist. There were four unfilled state positions listed. It was not designated whether these were for SLPs. The ratio identified by the facility was 1:75. It could not be determined how this was calculated. The two SLPAs could not be viewed on an equal basis with the SLPs because they were not licensed to conduct communication assessments or address swallowing/mealtimes. A current status of licensure was verified online for each of the clinicians listed above. A resume was submitted for David Ehrenfeld only who identified extensive experience focused largely in nursing homes and skilled nursing facilities. Brooke Shapiro was an SLPA, who received her degree in May 2010. She worked with individuals who had a stroke. Communication-related continuing education since the previous review included Texas Statewide Assistive Technology by the Region 4 Education Service Center listed with attendance by Jeaneen Abram, SLPA (1.15 CEUs), Ashley Canup, MS, CCC-SLP (1.15 CEUs), David Ehrenfeld, MSEd, CCC-SLP (1.25 CEUs), Charlese Turner, MS, CCC-SLP (1.3 CEUs) and Brooke Shapiro, SLPA (1 CEU). No evidence of continuing education was submitted for Cara Mattson MA, CCC-SLP since the previous review. Caseload assignments based ranged from 45 (Martin unit) to 152 (Whiterock/Longhorn). SLPs were responsible for assessments, attending PSPs and PSPAs, supports and	Noncompliance

#	Provision	Assessment of Status	Compliance
		services, program development, and monitoring in the areas of communication and mealtimes. Frances Harman was now identified as a fully dedicated member of the PNMT and it was unclear how her communication services caseload had been re-assigned. Though this level of staffing was essentially stable since the previous review, adequate and appropriate communication services had not been provided for the individuals who presented with significant communication deficits at MSSLC as outlined below. **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.** The MSSLC Master Plan was requested. The document submitted was a paper previously written and submitted last year outlining the facility's philosophies and rationale for prioritizing the provision of supports and services, and the three priority levels. This document did not provide the monitoring team with an understanding of the status of implementation of the plan in any way. The related database was not submitted. Fortunately, the Communication Master Plan Data Base (8/30/11) had been included in the Presentation Book. Per the Presentation Book for section R, all individuals identified as Priority 1 (81 individuals) and Priority 2 (61 individuals) had been provided a comprehensive communication assessment and there were only 28 of 138 individuals identified as Priority 3 who had not yet received an assessment. Everyone listed in the database (349 individuals) at all priority levels was identified as completed, with approximately 42 individuals not included, based on the census reported as 391 at the time of this review. No assessment dates were included in the database, so completion of assessments could not be validated by the monitoring team. Another list identified the completion dates of 161 assessments with the PSP dates for 151 individuals. There were 52 baseline assessments, 29 comprehensive assessments, 57 updates, and 21 CLDP assessments listed as completed since 3/18/11. Approximately 61% were completed at least one month, but less than 60 days, prior to the designated due date, 8% were completed on the due date, and 23% were completed after the due date. Seven assessments were completed over 60 days prior to the PSP and, as such, may not be sufficiently current for program planning. Seven assessments did not have a designated due date. Approximately 30 assessments were completed after the due date, but prior to the PSP meeting. Three assessments were listed as completed the day of the meeting and five were completed after the PSP, in some cases three to five months later	

#	Provision	Assessment of Status	Compliance
		(Individual #175, Individual #360, Individual #4, and Individual #243). A list identified only 23 individuals with one or more AAC systems, though an additional list included 32 individuals with one or more AAC systems. This represented only 16% (or 23% depending on the list) of those individuals identified as nonverbal or partially verbal (Priority 1 and 2). These had been provided as follows: • 2011: 5 • 2010: 24 • 2009: 13 • 2008: 2 • 2007: 4 • Unknown: 3 • On order, but not yet delivered: 3 These included the following: communication board, communication wallet, activity schedule, Go Talk 9+, Big Step by Step, Little Step by Step, Super Talker, Hip Talker, Dynavox Maestro (on order), Saltillo (on order), Trutone electrolarynx, Cheap Talk, Persona Mobile by Zygo (on order), sign language book, Big Mac switch, Big Talk Triple Play, Go Talk 4+, and a magnetic writing tablet. These systems appeared to be varied, individualized, and designed to be available to individuals across environments. It was of concern, however, that very few new systems had been provided, based on the assessments completed for individuals identified as nonverbal or partially verbal. There were 16 (25 based on the alternate list) of the individuals who were provided AAC who were also provided a Communication Dictionary. There were another 120 individuals (85%) with a Communication Dictionary only. This support was for staff use, only to interpret communicative efforts by the individual. It did not enhance or augment the individual's communication abilities. Only four individuals received some type of direct communication intervention. Records of 15 individuals were requested. Communication evaluations were contained in each of the records, though the assessments submitted for five individuals were not current within the last 12 months (Individual #490, Individual #518, Individual #304, Individual #197, and Individual #588). Assessments of another 29 individuals were reviewed. This included individuals participating in direct speech therapy and the five most current assessments for each clinician. Of these, 68% (26 of 38) indicated that the individuals presented with significant communication deficits. There were five Comprehensive Assessments, nine Baseline Assessments, four Speech-Language Evaluation – Baseline assessments, two	

#	Provision	Assessment of Status	Compliance
		Comprehensive Baseline Assessments, 15 Baseline Update Assessments, one Update Assessment, one Speech-Language Evaluation – Update, and one Baseline Assessment – Update current within the last 12 months. The format of only one of the eight (12.5%) Baseline Assessments submitted was consistent with the template submitted. Some Baseline Assessments reviewed were limited in content and appeared to actually be updates to a previous assessment rather than an assessment intended to establish a baseline status with regard to communication skills (Individual #452 and Individual #206, for example) The assessments were generally consistent across individuals as to format and headings, though the AAC section was extremely limited in content. Systems were selected based on very minimal evidence of consideration, or trials, of various options. For example, each of the assessments referred to a Lifespace Access Profile and the SETT Analysis. Though it was not clear how these were used for clinical analysis of findings. • Individual #266 received a Baseline Assessment on 5/9/11. It was reported that she had an environmental control switch to activate a massage pillow. It was further reported that she inconsistently used this and at times threw it when she did not want to use it. It was suggested that this be offered to her consistently, yet no recommendations for an SPO were identified. The only recommendation for improving communication was the Communication Dictionary, which was merely an interpretive guide for staff rather than a tool or system for use by the individual. Reassessment was scheduled for 2014 or in three years. It was of concern that she would not have appropriate supports to address her severe communication deficit or to optimize her communicative strengths and intent. • Individual #99 received a baseline evaluation on 10/28/10. His current method of communication was described as nonverbal through the use of facial expressions, movement toward/away from activity, eye gaze, gestures, touching, vocalizing, and a limited number of word approximations. It was reported, however, that he signed the name or action for pictures of at least 16 functional objects. It was further reported that he used 15 to 25 signs, though not in combination. He also used iconic pantomimes and was likely to pick up new pantomimes or signs during his daily routine. It was, however, then stated that this was a rationale for <u>not</u> developing an AAC system or training objectives to enhance or expand his existing skills, but rather only recommended continued use of the Communication Dictionary. He was to be provided an update evaluation prior to his PSP in 2011. There was no evidence that this had been provided to date at the time of this onsite review. • Individual #474 received a Baseline Evaluation on 11/4/10. Her current method of communication was described as nonverbal with a limited variety of communicative behaviors. Trial use of any assistive devices was not conducted	

#	Provision	Assessment of Status	Compliance
		for this assessment, but rather only reference to previous attempts describing that she had been provided a switch to activate a radio, that she did not demonstrate cause and effect, and was not interested in the product of switch activation. It was documented that she was interested in sensory exploration and in single objects. It was determined that the switch activity be discontinued and only a Communication Dictionary was recommended. It was reported that the SETT analysis framework was utilized for this assessment, though there was no real evidence of this in the report. It was reported that she did not appear to demonstrate anticipation of an upcoming event, such as being transferred from her chair or moved to sidelying. There was no consideration of a training objective or addition to her PNMP to include specific strategies to promote this. The clinicians reported that all individuals with potential to benefit from AAC had been evaluated and that each individual's needs had been met. It was of concern that the SLPs were not involved in the development of SPOs for use in day programs and the homes, as well as therapist-directed interventions in the form of individual programming or group activities. The assessments varied in the degree to which they would be considered comprehensive. As described above only 23 to 32 individuals were provided AAC. Only four individuals participated in direct communication-related therapy.	
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.	**All individuals in need of AAC are identified as being in need of AAC.** The most current assessments were essentially consistent as to content headings. The AAC and environmental access sections were very limited and, in many cases, did not reflect thorough review of possible options for assistive technology or skill acquisition programming. The rationale and recommendations did not consistently reflect a careful and thoughtful consideration of AAC systems, skill acquisition potential, and the consideration of learning opportunities designed and directed by the speech language pathologists. Some examples included: • The update assessment for Individual #188 dated 5/20/11 reported that two previous assessments determined that AAC was not appropriate. The clinician merely concurred rather than provide a current re-assessment. The rationale offered was that Individual #188 did not have symbol representation skills or comprehension skills to understand an idea could represent an object. The clinician stated that the results of current testing represented maintenance as compared to the evaluation the previous year. It was not clear how there would have been an expectation for any other outcome without enhanced level of supports and interventions. There were no recommendations related to communication supports other than a few strategies for staff use and a Communication Dictionary. It would be likely that with the current approach to supports and intervention, discernible change would be unlikely.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The baseline assessment for Individual #391 was dated 5/16/11. The clinician stated that she was not assessed for AAC, but that AAC was not appropriate for her. Individual #391 was described as a verbal communicator using one to four word utterances. She had a Behavior Support Plan and was described as uncooperative. Supports and interventions included a Communication Dictionary, structure and consistency in daily routines, and schedules with short manageable task requirements. An update was recommended in one year. This did not represent a comprehensive assessment. An update would be unlikely to yield additional information in the absence of communication supports. • The assessment on 4/21/11 for Individual #452 was described as a baseline, but the body of the report indicated that it was an update. He primarily used nonverbal communication, but also had some word approximations. There was no assessment for AAC, stating that this was unchanged since his baseline assessment. He had not been provided any communication-based supports or services in the last year and none were recommended in this most current assessment. Re-assessment was to be conducted in 2012, though it would not be likely to yield additional information in the absence of communication supports. • The assessment for Individual #167, dated 6/28/11, was an update to the baseline conducted on 8/2/10. The clinician described Individual #167 as nonverbal, lacking representation or the ability to use a symbol to stand for something else. It was reported that there had been no changes in her communication skills since the baseline. Though further assessment was not conducted for the current assessment, the clinician stated that AAC was not indicated for Individual #167. Staff were to use the Communication Dictionary and provide choice-making opportunities. Re-evaluation was not recommended until 2014 though the rationale for this was not stated. • Individual #503 received an update assessment on 4/18/11. He was described as nonverbal. He had been provided a Big Step by Step and a Little Step by Step with use described by the clinician. He did not appear to use the devices to communicate choices, but appeared to enjoy the social interaction they provided. It was recommended that these be continued, but there were no recommendations for supports or interventions designed or directed by speech staff to promote improved use and skill acquisition. • A Baseline Evaluation was conducted for Individual #494 on 11/4/10. It did not appear that an AAC assessment had been conducted, yet the clinician stated that she used had sufficient communication behaviors to indicate that she was wished the current activity to continue or to stop. She had inappropriate behaviors and was provided a BSP. The rationale provided for not providing AAC was described as her lack of skills of representation. She was able to request continuation of activity using the actual objects, but did not attend to	

#	Provision	Assessment of Status	Compliance
		symbols representing those activities. Individual #494 was reported also, however, able to use limited self-care related signs and thus demonstrated the skill of representation. This clinician appeared to envision systems that only included symbolic language, such as pictures rather than alternate systems to address activity transitions, requests, or choices using representational objects or expanded use of signs/gestures, for example. The only support recommended was the Communication Dictionary. The subsequent year update merely concurred with this finding rather than provide assessment. • Assessments for AAC was not conducted for Individual #511, Individual #339, Individual #505, Individual #524, Individual #302, and Individual #266 for their most current communication assessments. **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.** The current comprehensive communication assessment format generally addressed both verbal and nonverbal skills, and expressive and receptive language skills, and these were typically addressed in the assessments reviewed, though with very limited content. For example, the description provided regarding the current method of communication for Individual #340 was only that he communicated verbally in the form of words, descriptive phrases, and complete sentences. Examples or functional descriptions were not documented. The reader would not discern one individual from another in a number of cases based on the description of their communication abilities (e.g., Individual #206 and Individual #457). The assessments inconsistently included recommendations related to whether direct therapy or AAC was indicated. Communication Strategies was an assessment heading consistently used though the clinicians varied in their ability to offer strategies that were individualized. In some cases, these were merely recommendations for staff to refer to the Communication Dictionary or to contact the Speech Department if equipment was lost or in need of repair rather than strategies to improve or enhance communication skills or to promote staff skills. Recommendations for interventions or supports designed to enhance or expand existing communication abilities or to promote acquisition of new skills were severely. PSPs, PSPAs, assessments, SPOs and documentation related to intervention by speech were requested for the following individuals identified as currently participating in	

#	Provision	Assessment of Status	Compliance
		direct speech therapy (Individual #359, Individual #455, Individual #436 and Individual #428). A tremendous amount of unrelated documents were unnecessarily submitted as well. Documentation and integration into the PSP was inconsistent. Examples include the following: • Individual #428: The most current assessment submitted was dated 5/2/11. Direct speech therapy was recommended to address his stuttering because he had expressed interest in learning specific strategies to improve speech fluency. Though this was described in the PSP dated 6/8/11 as a needed support and service, there were no specific training objectives developed. A PSP addendum dated 8/31/11 reported that he was "doing better" and there was no need to continue direct therapy as of 8/30/11. There were no goals and objectives established and, as such, there was insufficient rationale for discontinuing this service. There was no evidence of any documentation related to the provision of speech therapy. • Individual #455: His most current assessment was a baseline completed on 1/8/11. Direct speech intervention was recommended to initiate trials with voice output devices. No SPO had been developed as of his PSP dated 3/30/11. Two SPOs were listed to increase his communication skills, including placement of work materials on the table and cleaning of his workstation, but here was no reference to the recommendation for AAC trials. A reference to the trials was noted in PSPAs dated 5/17/11 and 8/8/11, which reported that he continued with the trials and that he was benefitting. No specific report as to progress with specific measurable outcomes was documented. It was reported that he frequently requested to watch Barney videos. It appeared that he was permitted to engage in this non-age appropriate activity, but there was no consistency from session to session with regard to activities presented, specific outcomes, or his progress. There was only one monthly summary related to the AAC trials. This was undated, but stamped on 7/19/11. This summary or the progress notes did not indicate his success relative to the identified objectives or consistently identify the devices used. • Individual #428: His most current communication assessment, dated 5/2/11, recommended direct speech therapy to address a fluency disorder (stuttering). Integrated progress notes documented the evaluation on 3/14/11 with a PSP meeting on 5/3/11 where speech intervention was discussed by the team. Subsequent notes documented interventions from 6/30/11 to 8/29/11 (12 entries only). None of these identified specific measurable outcomes, nor was there evidence of progress toward a specific goal. His PSP was dated 6/8/11 with no communication-related SPOs identified. **Standard: If receiving services, direct or indirect, the individual was provided a**	

#	Provision	Assessment of Status	Compliance
		comprehensive Speech-language assessment at a frequency that ensured relevance and appropriateness of goals. As stated above, there were only four individuals listed as receiving direct speech services and the documentation for each of those were requested for review. Current communication assessments for each were submitted as follows: • Individual #359: Comprehensive Assessment (4/28/11) • Individual #428: Comprehensive Evaluation (5/2/11) • Individual #436: Baseline Update Assessment (3/18/11) • Individual #455: Baseline Evaluation (1/6/11) With the exception of Individual #436, each was scheduled for an update within the next year. Individual #436's assessment indicated that he would be provided a subsequent assessment in 2013. This would not be acceptable given that he was also recommended for direct speech therapy. Integrated progress notes were written on three dates only from 3/18/11 to 6/28/11 and none of these identified the focus of intervention, outlined any intended outcome of therapy, or described his progress. Documentation did not meet basic generally accepted professional standards of care. There were approximately 143 individuals identified as Priority 1 and 2, or most likely to benefit from AAC, yet none of these individuals participated in direct communication supports. Only 19% of those identified as Priority 1 and 2% of those at Priority 2 were provided some type of AAC system. **Standard: Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.** Specific skill acquisition outcomes were not delineated in any of the assessments reviewed. **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. Communication programs are integrated into the PBSP as indicated.** There was no specific screening or assessment process for those with behavioral concerns and potential need for AAC. There was no policy related to the identification of behavioral challenges and related communication deficits. Lists were requested of individuals with communication-related	

#	Provision	Assessment of Status	Compliance
		replacement behaviors in their PBSPs (not submitted) and also for individuals who had behavioral concerns and severe communication/language deficits (60 individuals identified). The assessment used for those who received behavioral supports (approximately 222) was the same used for other individuals living at MSSLC. As the Master Plan did not include the names of individuals who had yet to receive a communication assessment, this list was not cross checked with the list of individuals who had PBSPs. It was not clear how many of the remaining individuals also had PBSPs. Also, the Master Plan listed the assessments only as completed and did not include dates of completion. It was estimated that many of the communication assessments completed would not be considered comprehensive and appropriate based on those reviewed. Only six of the individuals for whom communication assessments were submitted were identified as having behavioral issues with coexisting language deficits, though 20 of the 37 assessments reviewed by the monitoring team were listed with PBSPs. While most of the assessments made reference to a PBSP, there was limited or no discussion of how or if limitations in communication skills contributed or exacerbated behavioral concerns. Substantial compliance in this area would not be achieved by merely describing the PBSP in a section of the communication assessment. Collaboration between SLPs and psychology related to assessment and analysis of associated communication and behavioral concerns, as well as in the development and implementation of related training objectives, is required. **Standard: Communication programs were integrated into the BSP as indicated.** PBSPs were submitted for five individuals included in the sample reviewed and each was current within the last 12 months. Each of these individuals was identified with significant speech/language deficits. There was no evidence of collaboration between speech and psychology staff for the development of communication, behavior, or training supports. In May 2011, Habilitation Therapy and Psychology initiated a collaborative program (Occupational Therapy, Behavior/Speech, OBS) to address the needs of individuals with behavior, sensory, and communication needs. This program had been recently implemented in the day program area. Evaluation of the effectiveness of this program should be a collaborative process as well. **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. A separate list was submitted in	

#	Provision	Assessment of Status	Compliance
		response to a request for assessments and the dates of completion. The Master Plan as outlined in the policy was intended to prioritize those individuals who would most benefit from AAC devices or equipment. The MSSLC Master Plan submitted identified some individuals at three different priority levels, though only those who had received assessments to date were included. The dates of the assessments were not in the plan so it was unclear if these were current relative to format and content.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	**Standard: Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP.** Of the PSPs submitted for review, only one was not current within the last 12 months (Individual #490, 8/2/10). With the exception of Individual #359, the only communication supports for those individuals reviewed consisted of a Communication Dictionary. This was identified in the PSP for only 17 individuals who had them. A communication wallet was recommended for Individual #359, but there was no training objective related to its use. **Standard: The PSP contains information regarding how the person communicates and strategies staff may utilize to enhance communication.** There were: • no descriptions of expressive or receptive communication skills outlined in the PSPs for 13% of those reviewed. • very minimal descriptions of receptive and/or expressive communication included in the PSPs for 42% of those reviewed. • limited descriptions of receptive and/or expressive communication with limited strategies for staff use outlined in 45% of the PSPs reviewed. **Standard: Communication information is not only present in the PSP but integrated into the daily schedule** As stated above, adequate information related to communication was not present in the majority of the PSPs reviewed. There were brief statements related to communication in the PNMPs, but there was no evidence that this was integrated throughout the day. This also did not include strategies for use by staff in order to be an optimal communication partner with the individuals they supported. There was no staff training or assistance to develop SPOs or to provide modeling and support for effective implementation of the communication strategies recommended in the communication assessments. By report and by observation, AAC systems provided to individuals were not consistently implemented throughout the day or across settings.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Standard: AAC devices are portable and functional in a variety of settings. The majority of systems provided were intended to be functional and many were portable for use across a variety of settings, however, see the paragraph immediately above. **Standard: AAC devices are individualized and meaningful to the individual.** The limited systems provided appeared to be individualized and potentially meaningful to the individual. Consistent implementation continued to be a concern and, as such, meaningful and functional use by the individual was often not possible. A number of individuals who would likely benefit from communication supports were only provided a communication dictionary, but this was an interpretive guide only for staff use. There was no mechanism to ensure that the strategies recommended in the assessments were effectively implemented by staff. **Standard: Staff are trained in the use of the AAC.** Direct support staff did not appear to be knowledgeable regarding communication programs. No communication systems were observed being used. There were no general use devices noted. By report, NEO staff training in the area of communication was largely lecture with no opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. **Standard: Communication strategies/devices are implemented and used.** While the general interactions of staff with the individuals they served were generally positive, much of 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.	

#	Provision	Assessment of Status	Compliance
		Standard: General AAC devices are available in common areas. General use devices were not available at the time of this onsite review. 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. As stated above, there appeared to be insufficient time devoted to hands-on training, modeling, and reinforcement of the appropriate implementation of communication supports of any kind, including AAC. There was no evidence of formal communication programs submitted and SLP support was not available to ensure sufficient supports for appropriate and routine implementation of the recommendations addressed in the communication assessments. As observed during the previous review and again during this review, the position of many individuals was not optimal to promote visual or physical participation in communication activities.	
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: Monitoring system is in place that: tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device.** There were no policies related to a monitoring system for AAC. The PNMP Monitoring Form was used to monitor AAC. Completed forms for the last month were requested and 15 forms for 10 individuals were submitted. These forms were completed largely by PNMPCs and, as such, it was not possible to determine the effectiveness of the devices for these individuals. There was no analysis of the monitoring data or process to inform and direct staff training or system change. These forms documented 100% compliance with implementation, but represented only 5% of individuals with AAC. Two individuals monitored were not listed with communication supports (Individual #514 and Individual #48). **Validation checks are built into the monitoring process and conducted by the plan's author.** There was no evidence of validation monitoring conducted with the PNMPCs related to communication at the time of this review. PNMPCs had not yet been competency trained to conduct this monitoring.	Noncompliance

Recommendations:

1. Establish a clearly outlined strategic plan to direct the activities of the speech clinicians that will focus on those actions necessary to make progress toward and achieve substantial compliance with each item of this provision. The development of the POI should be clearly related to activities conducted to assess status based on record review, observations, training drills, and so forth, and the actual implementation of actions in the strategic plan with documentary evidence. These should be reported in the POI and serve as the foundation for the assignment of compliance or noncompliance status by the facility (R1-4).

2. Review the current format and content of NEO staff training. Revise as indicated to ensure that the focus is for new staff to develop skills as effective communication partners. This should by interactive and dynamic with opportunities for role playing and practice. One hour of training in this area is insufficient to address this critical area for supports and services. Staff cannot learn what they need to in such a short time (R1).

3. Review existing comprehensive assessments for those who were identified as Priority 1 and 2 to determine if these assessments met the standard as outlined per the SA (R2).

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 (R3).

5. PNMPs should include descriptions of expressive communication as well as strategies for use by staff (R3).

6. There is an urgent 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. The existing OBS program did not appear to have sufficient input and participation from professional staff to ensure that it was functional, meaningful and outcome based (R1).

7. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs (R3-R4).

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:** Documents Reviewed: o Personal Support Plans for: • Individual #331, Individual #227, Individual #461, Individual #264, Individual #6, Individual #319, Individual #242, Individual #521, Individual #367, Individual #127, Individual #359, Individual #177, Individual #536, Individual #51, Individual #332, Individual 540, Individual #537, Individual #571, Individual #452, Individual #291, Individual #340 o Specific Program Objectives (SPOs) for: • Individual #6, Individual #319, Individual #227, Individual #331, Individual #242, Individual #521, Individual #461, Individual #264, Individual #422, Individual #376, Individual #233 o Six months of master teacher data and progress notes for: • Individual #6, Individual #319, Individual #227, Individual #331, Individual #242, Individual #521, Individual #461, Individual #264, Individual #422, Individual #376, o Engagement Monitoring Form, undated o Skill Acquisition Plan/SPO Checklist, 6/29/11 o Community Training spreadsheet, 5/11 o Self-assessment overall progress graph, April, May, June, July, and August of 2011 o Self-assessment data, August, 2011 o Engagement data by home, undated o Plan of Improvement, dated September 8, 2011 o Section S Presentation Book o A list of Individuals with dental desensitization plans, undated o List of individuals who were under age 22 and their school assignment o MISD classroom roster, 9/19/11 o ARD/IEP meeting schedule, September 2011 o Report of a serious aggressive incident by one individual at the MISD Development Center 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 #177, Individual #127, Individual #359 Interviews and Meetings Held: o Don Morton, Director of Education /Training o Tammy McCulloch, Rehabilitation Counselor o Joann Cooper, Active Treatment Coordinator

	o Amber Wright, RN, SAM/HIPS Director o Norvell Starling, MSSLC liaison to MISD o Greg Goodrum, MISD director of alternative programs o Melinda Heaton, MISD counselor; Victor Carroll, MISD security o Shelly Wright, MISD Mexia High School classroom behavior specialist <u>Observations Conducted</u>: o Observations occurred in every day program and home 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 o MISD classrooms at the Development Center public school campus o MISD classroom at Mexia High School
	Facility Self-Assessment: MSSLC submitted its Plan of Improvement (POI), dated 9/8/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the facility identified what tasks have been completed and the status of each provision item. The POI did not indicate how the findings from any activities of the self-assessment were used to determine the self-rating of each provision item. 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. 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 throughout the facility, and because it will likely take some time for MSSLC to make these changes, the monitoring team recommend that the facility establish, and focus their activities, on selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	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, the monitoring team noted several improvements since the last review. These include: • Specific Program Objectives (SPOs) have been revised to include a rationale for the program • The establishment of a new engagement monitoring team • New tracking methodology for training activities in the community • Began to incorporate replacement behaviors in the SPO format • Improved individual engagement scores The monitoring team suggest that the facility focus on the following over the next six months: • Expand new SPO format to all SPOs written at MSSLC. • Ensure that the rationale for each SPO clearly states how acquiring this skill is related to the individual's needs/preference. • Ensure that all of the components necessary for learning new skills are included in each SPO • Expand the methodology used to teach SPOs • Collect and track SPO integrity measures

#	Provision	Assessment of Status	Compliance
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. There had been consistent improvements, however, more work needs to be done to achieve substantial compliance. <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 made progress in this area since the last review. The SPO training instructions	Noncompliance

#	Provision	Assessment of Status	Compliance
		sheet had been modified to include the justification for training and individual preferences. SPOs for five of 11 individuals reviewed (45%) clearly stated the needs and preferences for each SPO and, therefore, appeared to be functional and practical. For example: • Individual #233's SPO for banking stated that he wanted to live in the community, and that he had needs in the areas of money management, which would better prepare him for the community. • Individual #521's SPO for operating a microwave oven stated that Individual #521 enjoyed cooking and she did not know how to operate a microwave oven. On the other hand, the rationale for six SPOs reviewed contained a general statement that the SPOs were based on individual need and preference, but did not include a more specific rationale for why the particular SPO was chosen. Therefore, it was difficult to determine if these SPOs were practical and functional. For example: • Individual #264's SPO stated that he wanted a job, and to live with his mother, but did not indicate what a practical job might be, or his specific needs that would justify why he had an SPO for adding and subtracting numbers. • Individual #227's SPO stated that he wanted to move to a group home, earn money, and listen to music. It was not clear, however, how his SPO of calendar skills was functional and practical. The monitoring team was encouraged by the new SPO format that attempted to ensure 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 specific enough for the reader to determine if the SPO was practical and functional for that individual. Additionally, it is recommended that the new SPO format be extended to all SPOs written at the facility, including the SAM/HIP SPOs. 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	

#	Provision	Assessment of Status	Compliance
		• Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology An SPO monitoring tool was recently developed to ensure that the above components had been included. The facility's self-assessment indicated that none of their sample of SPOs contained all of the above components. The monitoring team's assessment was consistent with this evaluation. Particular problems appeared to be specific consequences for correct and incorrect responses, the inclusion of behavioral objectives, description of training conditions, and 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. One strategy that may be helpful to the facility to better ensure that these components are present in every SPO is to include each component in the SPO training sheet. The facility continued to use the same methodology for training the majority of SPOs. This training generally consisted of least-to-most prompting throughout the entire target behavior. For example, using the least prompting necessary to have an individual successfully apply lotion to his or her hands. This methodology clearly can result in the acquisition of new behaviors. There are, however, several other methods that can be used to train SPOs (e.g., backward and forward chaining). It is recommended that the facility expand their training methodologies. <u>Desensitization skill acquisition</u> Dental desensitization programs were being developed and monitored by the psychology staff at MSSLC. These skill acquisition plans were designed to teach individuals to tolerate dental interventions, and can result in a decrease in the use of sedating pre-examination medication. A spreadsheet of dental desensitization plans indicated that only five individuals at the facility had these plans at the time of the onsite review. Additionally, only one of these plans was written since the last review. As indicated in the last review, these SPOs contained the majority of the necessary components listed above. Future reviews will assess if additional dental desensitization programs are required (see section L for a discussion of the need for dental desensitization plans at MSSLC), and assess specific outcome data. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> As discussed in the last report, MSSLC included replacement/alternative behaviors in each PBSP. There were descriptions of teaching conditions (see K9), however, the format was not consistent and the quality and detail of the training varied greatly. It was	

#	Provision	Assessment of Status	Compliance
		recommended that replacement/alternative behavior training procedures should be incorporated into the facility's general training objective methodology. The facility recently began to include replacement/alternative behavior training in the SPO methodology. The monitoring team encountered two examples of an alternative behavior found in the PBSP included as a SPO (i.e., Individual #242's communication objective, and Individual #233's work-related behaviors). It is recommended that the facility continue to incorporate alternative/replacement behaviors that require the acquisition of a new skill into SPOs. The monitoring team looks forward to seeing more examples of replacement/alternative behaviors from PBSPs as SPOs in the next review. <u>Communication and language skill acquisition</u> SPOs for three of the 11 individuals reviewed had skill acquisition programs targeting the enhancement or establishment of communication and language skills. This represented an increase in the number of communication SPOs at the facility. It is recommended that the facility continue to expand the number of communication SPOs for individuals with communication needs. <u>Service objective programming</u> Finally, the facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). These were also 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 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	

#	Provision	Assessment of Status	Compliance
		homes visited, many of the individuals were out of the homes, engaging in activities (e.g., at a dance on campus, in the community). 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 that did not require the active participation of staff. 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 score across the facility was 66%, an increase over that observed during the last review (i.e., 59%). An engagement level of 75% is a typical target in a facility like MSSLC, indicating that the engagement of the individuals at MSSLC continued to have room to improve. In an attempt to more accurately assess and enhance engagement, the facility recently hired a new Active Treatment Coordinator, reorganized the staff collecting engagement data, and modified the methodology to assess engagement levels. The monitoring team was encouraged by these changes and the steady improvement in individual engagement observed. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
C7	0/4	3:4
C7	1/1	1:1
M7 and M8	3/8	4:8
M7 and M8	2/6	2:6
W1	2/3	2:3
W1	2/2	1:2
W5	3/3	0:3
W5	1/1	2:1
B1	1/2	1:2
B7 and B8	1/2	1:2
L3	1/3	1:3
L4	6/6	3:6
W7	5/5	2:5
W8	1/1	1:1
Step Center Classroom	3 /8	2:8
Step Center Classroom	6/8	2:8
Step Center Classroom	3/8	2:8
Step Center Classroom	3/8	2:8
Vocational Workshop	13/16	5:16
Vocational Workshop	11/16	6:16

#	Provision	Assessment of Status	Compliance
		Woodshop | 5/6 | 3:6 Educational Services A good working relationship with Mexia Independent School District (MISD) continued to develop. During this onsite review, the monitoring toured the MISD Development Center campus and classrooms (seven) in town and visited the Mexia High School special education program and classroom (one) that MSSLC students attended. It appeared that MISD and MSSLC were working well together to keep students in school in as integrated a setting as possible, maintain their engagement in academic tasks, and help them work towards obtaining their high school diplomas. This was all very good to see. The MSSLC liaison to MISD reported that the number of students who were attending school at the public school campuses had increased since the time of the last onsite review (as was their goal). At this time, 18 students were at the MSSLC campus school (it was 36 last time), 47 were at the Development Center (it was 27 last time), and four were at the high school. Eleven students were at the high school last time, but nine of them had graduated and MISD and MSSLC expected a number of students to transfer from the development center to the high school over the next few months. The monitoring team had the opportunity to meet and talk with the MISD director of alternative programs, Greg Goodrum, and other MISD counselors, teachers, and staff. All seemed supportive of MSSLC students being part of the public school and supporting their academic progress. Further, extended school year was considered and provided for those students for whom it was appropriate. This was also good progress from the last onsite review. MISD and MSSLC were reported to be collaborating in a number of ways, such as MSSLC master teachers incorporating IEP objectives into MSSLC campus objectives. Further, the high school behavior specialist reported having frequent conversations with the students' MSSLC psychologist. MSSLC observations of the on-campus classrooms continued to be completed. The monitoring team does not have any further recommendations for MSSLC regarding the educational services component of this provision item.	
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	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. At the time of the onsite review, the facility was beginning the use of the Functional Skills	Noncompliance

#	Provision	Assessment of Status	Compliance
	of living, working, and engaging in leisure activities.	Assessment (FSA) to replace the Positive Adaptive Living Survey (PALS) for the assessment of individual skills, and as part of the method of identifying skills to be trained. The monitoring team looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing, speech/language pathology) and individual preference, to identify meaningful individualized skill acquisition programs. Finally, while the PSP attempted to identify individual 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.	
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	MSSLC continued to make progress on this provision item. More work, however, in the areas of integrity of the implementation and the practicality and function of SPOs (see S1) 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., signing for walk for Individual #521, typing for Individual #461). Additionally, modifications in training were specified for SPOs that were not progressing (e.g., the level of assistance provided was modified for Individual #319's picking out clothes SPO, due to lack of progress). As during the last review, the implementation of SPOs was observed to evaluate if SPOs were implemented as written. The monitoring team was pleased to find that all of the SPOs observed appeared to be conducted as written and staff were able to explain how to implement the plans. Nevertheless, the only way to ensure that SPOs are implemented as written is to conduct integrity checks. Although integrity measures were discussed during the previous onsite review, no integrity data were available for review at the time of this onsite review. It is recommended that a plan be developed to collect and graph integrity data to ensure that SPOs are conducted as written.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(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 training in the community. More work, however, is necessary to achieve substantial compliance. The facility began tracking of community training prior to the last onsite review. The documentation, however, did not clearly differentiate between community outings that had general socialization objectives from community outings that included the implementation of SPOs. The community outing form has recently been modified to better capture training of SPOs in the community. The monitoring team will review these data from the new form in future reviews. At the time of the review, 20 individuals at MSSLC worked in the community. This represented a decrease in the number reported during the last onsite review (i.e., 27). The monitoring team was encouraged by the facility's progress on this provision item and looks forward to seeing continued progress at the next review.	Noncompliance

Recommendations:

1. It is recommended that all SPOs at the facility use the new SPO format. Additionally, MSSLC should ensure that the rationale for each SPO clearly states how acquiring this skill is related in the individual's needs/preference (S1).
2. The facility should ensure that all of the components necessary for learning new skills are included in each SPO (S1).
3. The methodology used to teach SPOs should be expanded (S1).
4. It is recommended that the facility continue to incorporate alternative/replacement behaviors that require the acquisition of a new skill into SPOs (S1).
5. The facility should continue to expand the number of communication SPOs for individuals with communication needs (S1).
6. It is recommended that a plan be developed to collect and graph integrity data to ensure that SPOs are conducted as written (S3).

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 MSSLC facility-specific policies, Admissions, 9/1/11, Placement Team Review, 9/15/11, Placement Review and Appeals, 9/15/11 o Organizational chart, 9/1/11 o MSSLC policy lists, three policy books, July 2011 and August 2011 o List of typical meetings that occurred at MSSLC o MSSLC POI, 9/8/11 o MSSLC Admissions and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/19/11 o Community Placement Report, 2/1/11 through 8/16/11 o List of individuals who were referred for placement and had been placed since last onsite review (25 individuals) o List of individuals who were referred for placement and had not yet been placed (49 individuals) • Secondary list showing status of each referral, scheduled move date, etc. • List included indication if referral was more than 180 days (21 individuals) o List of individuals who requested placement, but weren't referred, (160 individuals) • Table summarizing the reasons for these individuals not being referred o List of individuals who requested placement, but weren't referred solely due to LAR preference, (67 individuals) o List of rescinded referrals (20 individuals) and PSPA notes regarding each rescinding o List of individuals returned to facility after community placement (0 individuals) o List of individuals jailed or psychiatrically hospitalized at some point after placement (3 individuals) o List of individuals discharged under alternate discharge procedures and related documentation (3 individuals) o List of individuals who have died after moving from the facility to the community since 7/1/09 (8 individuals, 2 since the last review) o Placement Review Team minutes for last six months o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the PST's recommendation, if any, for movement to the community o List of trainings and educational opportunities for individuals, LARs, families, and MRAs, 10/1/10

	through 7/29/11, including the provider fair, activities with the local MRAs, trainings for MSSLC staff, training at a self-advocacy meeting, a list of CLOIP worksheets completed, and information about tours of community providers o Completed checklist tools used by APC regarding assessment submissions for CLDP o Emails from state office regarding plans to address obstacles system wide o Document titled Community Placement Obstacles, 9/1/10 to 7/25/11 o List of individuals who had a CLDP completed since the last review (31 individuals) o DADS central office written feedback on CLDPs (12 individuals) o PMM tracking sheet listing post move monitoring dates due and completed o PSPs and associated assessments for: • Individual #108, Individual #592, Individual #39, Individual #264, Individual #115, Individual #599, Individual #526, Individual #338, Individual #547, Individual #149, Individual #255, Individual #11, Individual #84, Individual #191, Individual #496 o CLDPs for: • Individual #599, Individual #526, Individual #338, Individual #547, Individual #149, Individual #255, Individual #11, Individual #84, Individual #191, Individual #496, Individual #402, Individual #413 o In-process CLDPs for: • Individual #394, Individual #358, Individual #167 o Pre-move site review checklists for: • Individual #599, Individual #526, Individual #338, Individual #547, Individual #149, Individual #255, Individual #11, Individual #84, Individual #191, Individual #496, Individual #402 o Post move monitoring checklists conducted since last onsite review for: • Individual #599, Individual #526, Individual #338, Individual #547, Individual #149, Individual #255, Individual #11, Individual #84, Individual #191, Individual #496, Individual #402, Individual #186, Individual #430, Individual #450, Individual #408, Individual #111, Individual #180, Individual #271, Individual #509, Individual #298, Individual #232 <u>Interviews and Meetings Held</u>: o Alynn Mitchell, Admissions and Placement Coordinator o Sarah Ham, Post Move Monitor o Sarah Ham, Jeanette Reaves, Gail Salinas, Pamela Gonner, Dana Cotton, placement specialists and admissions placement staff o Fred Dunham, Heidi Zerkle, Bobbie Walker, Kashara Rhynes, Daybreak community provider residential, day, and management staff o Diann Thomas, Debbie Bregette, DADS state office community placement staff o Tom Harlow, Heart of Texas MRA CLOIP staff o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs

	Observations Conducted: o CLDP Meeting for: • Individual #413 o PSP Meeting for: • Individual #379 o Community group home and day program visit for: • Individual #402 o Many residences and day programs at MSSLC
	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. It was updated on 9/8/11. In addition, during the onsite review, the APC reviewed the presentation book for this provision and discussed the POI at length with the monitoring team. The POI, for the most part, did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the APC wrote a sentence or two about what tasks had been completed and/or the status of each provision item, usually there was an extra every month or every other month. For some of the provision items, the APC referred to scores on the department's statewide self-assessment tools. It did not, however, indicate if those scores were specifically for the content of the corresponding provision item or if it was the overall score on the total self-assessment tool. This should be made more specific. In future POIs, to present a more complete description of the self-assessment process the facility should describe what actions it took, such as observation, interview, and review of a sample of documents. These are the types of activities taken by the monitoring team as part of this compliance review. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The APC self-rated the facility as being in substantial compliance with five provision items: T1c2, T1c3, T1d, T1h, and T4. The monitoring team was in agreement with all of these self-ratings, though again, it was unclear from discussions with the APC and from a review of the POI how MSSLC came to any of the self-ratings in the POI. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps were numerous and addressed almost every item of provision T. This type of full set of action plans should help MSSLC move towards substantial compliance. The action steps should be (a) revised based upon this most recent onsite monitoring report, and (b) prioritized with target dates for each.

	Summary of Monitor's Assessment MSSLC continued to make progress towards meeting provision T of the Settlement Agreement. Many individuals continued to be referred for placement and many continued to be placed in community programs all over the state. The number of individuals in the referral process and being placed appeared to be manageable and appropriate. Progress had been made in placing individuals who had been referred for more than 180 days. Admissions and placement is likely to remain an active and important component of the service program at MSSLC. The monitoring team recommends that the department's data be summarized and graphed every six months, and that the data be incorporated into the facility's QA program. Thorough reviews of any failed placements, including individuals who, after moving to the community, died, were jailed, were admitted to a psychiatric facility, or returned to MSSLC need to occur. The opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required. Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. Another revision to the PSP process was recently initiated under the guidance of three DADS consultants. The consultants will need to work closely with the DADS coordinator of most integrated setting practices to ensure that the requirements of provision T are included, such as the LOD. Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle was not explicitly noted in most cases. PSTs may need to describe reasons for not making a referral separately from obstacles to making a placement happen (e.g., provider capability). The monitoring team remains in agreement with DADS position, that is, that the availability of community resources must not be factor in deciding whether to refer an individual for placement but would be a determining factor in the decision to actually place the individual. A number of activities were occurring to educate individuals and their LARs, however, this needs to be individualized and incorporated into the PSP. Feedback obtained from some of these activities (e.g., provider fair, community tours) should be used by the APC for future planning. PSTs were becoming more involved in the referral process and in the selection of providers. MSSLC had good working relationships with the local MRAs and local providers. The new CLDP process had only recently been implemented. Soon to occur was the initiation of the CLDP at the time of referral. There continued to be serious problems with the facility's ability to develop an adequate list of essential and nonessential supports in the CLDP. Instead, most focused primarily on the provision of inservices, the scheduling of appointments, and the presence of items and plans rather than their use and implementation. There were few supports that were directly related to actions that were to

	occur day to day for each individual, such as implementation of preferred activities,. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns. Post move monitoring had improved since the previous review. Site visits were occurring regularly, reports were being completed, and the four staff directly involved in doing post move monitoring were professional and committed to doing a good job. A number of further improvements, however, are necessary for the facility to achieve substantial compliance with post move monitoring.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	MSSLC continued to have an active admissions and placement department led by Alynn Mitchell, the Admissions and Placement Coordinator (APC). She continued to be assisted by the Post Move Monitor (PMM) Sarah Ham, three other placement specialists, and an administrative coordinator. All six staff appeared to be quite busy with many referral, planning, placement, and monitoring activities. The specific numbers of individuals who were placed and who were in the referral and placement process remained stable and appeared to be manageable. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 25 individuals had been placed in the community since the last onsite review in mid-March 2011. This compared with 23 individuals who were placed at the time of the previous review, and with 63 individuals who had who had been placed at the time of the prior review. o This stable number reflected the changes made during the last onsite review, that is, to spend more time thoughtfully planning for each transition. • 27 individuals were referred for placement since mid-March 2011 and had not yet been placed. This compared with 18 individuals and 44 individuals who had been referred at the time of the last two reviews, respectively. o This was a relatively stable number and indicated continued referrals by the PSTs. • The total number of individuals on the active referral list was 49 at the time of this review. It was 73 at the time of the previous review. Fewer individuals on the list had passed the 180-day timeline. o The APC reported that there was much effort and success in reducing the number of individuals who were over the 180-day limit. As a result, only 21 names remained, and about half of these had placement dates	Noncompliance

		scheduled. • 160 individuals were described as having requested placement, but were not referred. This compared with 168 individuals and 40 individuals at the time of the last two reviews, respectively. o Of these 67 were listed as not being referred solely due to LAR preference. o Individuals who have requested placement, who do not have an LAR, and who are not referred should be reviewed via Placement Review Team or some other process. • The referrals of 20 individuals were rescinded since mid-March 2011. o Each individual's PST met and a PSPA report was issued that provided information indicating that the decision to rescind was reasonable. o Placement Review Team reviewed each of these rescinded referrals and made relevant and thoughtful comments. This was a noticeable improvement from the last review. • 4 individuals were discharged under alternate discharge procedures (see section T4 below). • 3 individuals were jailed or were hospitalized for psychiatric conditions after their move to the community. o Each of these cases should be reviewed by the APC and her staff to determine if anything different might have been done during the placement and post move monitoring process. • 2 individuals had died since being placed since the last onsite review. One was placed almost two years ago, the other was placed more recently. o This second case should be reviewed, in detail, by the facility. The review should focus upon whether anything different might have been done during the placement and post move monitoring process. o APC and facility thorough review (i.e., as if a sentinel event) of individuals who have died since placement (or had failed or otherwise troubled placements) was raised as a serious concern in the previous monitoring report, but had not been addressed by the facility. Each of the above eight bullets should be graphed separately. The monitoring team recommends creating simple line graphs with one data point representing six months of data (preferably to coincide with the onsite reviews, that is, March-August and September-February). These data should be submitted and included as part of the facility's QA program (see sections E above and T1f below). The monitoring team is available to help the facility create this graphic presentation prior to the next onsite review. In addition, the APC should do a review of every rescinded referral and every case when	

		an individual returned to the facility, even if for a respite. Perhaps a thorough review (i.e., treating it as a type of sentinel event for the admissions and placement department) might lead to changes in these processes for some, or if not all, individuals at MSSLC. <u>Determinations of professionals</u> This provision item 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 assessment process, during the annual PSP meeting, and be documented in the written PSP. In the PSPs listed above under Documents Reviewed, 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 on this important matter. In most of the PSPs, there was a sentence stating the PST determined the most integrated setting to be the individual's current home. In only a few cases was a rationale provided and in no cases were the determinations and opinions of the professional members of the PST indicated. Many examples were provided in the previous monitoring report. Similar examples were found during this review, but are not listed again. Moreover, when reviewing the assessments attached to each of the PSTs, none included a statement of that professional's determination and opinion regarding referral and placement in the community. The facility will need to 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. It appeared that the upcoming work on again revising the PSP process (see T1b1 below and section F above) will include the incorporation of professional's determinations within the PSP meeting, PSP document, and the assessment written by each professional member of the PST. This was discussed in a meeting with the DADS central office coordinator for most integrated setting practices, the DADS consultant for PSPs, the APC and PMM, and the monitoring team in various meetings over the past few months. <u>Preferences of individuals</u> The preferences of individuals appeared to be important to MSSLC PST members. This was evident in the way multiple providers were considered, in the discussions of individual needs, and in the individualized way in which providers were chosen. In some cases, individuals visited two or three different providers. In other cases, once a desirable provider was identified, the provider was chosen and placement moved	

		forward. PSTs attempted to have individuals move with their friends, long time housemates, and, in one case, with a family member who was also a resident at MSSLC. PST members visited most of the homes before individuals moved, though this did not appear to be the case every time, perhaps due to the location elsewhere in the state. A PST member should visit all homes and day programs that are being considered, or at a minimum, prior to the finalization of the choice of provider. Most of the individuals in the forensic units requested referral to the community. This was considered by PSTs, however, additional activities (e.g., Placement Team Review for those who do not have an LAR) will need to occur. The APC, PMM, and other admissions placement staff were very knowledgeable about the community provider system. They knew the most about the competence and capacity of providers. They should have a way to provide this information to PSTs, families, and individuals. Further, the facility might consider assigning a staff member (perhaps the PMM) to visit all of the local community providers and assess their services, quality of their homes, activities that are available to individuals, work and employment opportunities, and so forth. This information may then be very useful to PSTs, individuals, and family members/LARs. <u>Preferences of LARs and family members</u> MSSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. <u>Senior management</u> The APC continued to complete a weekly enrollment report. It was submitted to senior management each week. Senior management, however, would benefit from more detail regarding the status of each referral. To that end, the monitoring team recommends that the APC model the weekly report on that of the Lufkin SSLC, called "Weekly Admission, Inquiries, and Referrals Update." Due to the large number of individuals in the referral and placement process, modifications to the Lufkin SSLC model might be beneficial to MSSLC.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies,	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, dated 3/31/10. The APC reported that the facility followed the state's policy. MSSLC had three policies related to admissions and placement. All three had been revised in the weeks prior to this onsite review. These facility-specific policies were	Noncompliance

	procedures, and practices shall require that:	regarding placement reviews and appeals (Administrative-21), Placement Review Team (Committees and Councils-39), and Admissions (Client Management-11). Implementation of the new state policy, the updating of facility policies to make them in line with the new state policy, and subjecting the facility-specific policies to the requirements of section V2 will lead MSSLC towards compliance with this provision item.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	This provision item was found to be in noncompliance based upon the need for implementation of a process to adequately identify the protections, services, and supports that need to be provided to the individual, as well as the identification of obstacles to movement to the most integrated setting and a plan to overcome those obstacles. DADS and the SSLCs were embarking on another revision to the PSP process. This was the third (or so) revision to the process since the initiation of the Settlement Agreement, however, this was not unexpected because revisions to such a major part of service provision often require repeated revisions, modifications, or even overhauls. The monitoring team wishes to acknowledge DADS' efforts to continue to work to improve the PSP process so that it meets the needs of the individuals while continuing to progress towards meeting substantial compliance with the Settlement Agreement. To this end, DADS recently brought in three consultants to work on developing a new PSP format, new expectations, and updated training for staff. The consultants will learn about the current system, develop a new PSP document format, revise the way the meeting is conducted, and provide training to staff. Moreover, the consultants were working with the DADS central office coordinator of most integrated setting practices to ensure that the many requirements of provision T would be addressed. The consultants had not started any work at MSSLC as of the time of this onsite review. Four of the annual PSP meetings held during the week of the onsite review were observed by the monitoring team. In addition to attending PSP meetings, five recently completed PSP documents were reviewed (listed above in the Documents Reviewed list) as well as the PSPs for 10 of the individuals who had been placed since the last review. The total sample included individuals representing different levels of referral for placement, ages, need for extensive supports, language abilities, medical needs, and family involvement. These five recent PSPs were chosen by MSSLC, and sampled from each of the five units on campus. <u>Protections, Services, and Supports</u> The same comments regarding the contents of an optimistic vision and the living options discussion that were presented in the previous monitoring report continued to be	Noncompliance

		applicable at the time of this review (but are not repeated here). PSP meetings continued to be led by three PSP coordinators whose primary job was to facilitate (i.e., lead) PSP meetings and create the written document. As a result, there was a great deal of consistency across the PSP documents reviewed and the PSP meetings observed. Although numerous changes will be occurring given the impending PSP process revisions, MSSLC should be uniquely poised to progress quickly given the existence of the highly focused roles of the PSP coordinators. Even so, in order to accomplish this, the APC and the QMRP coordinator will need to work together. Overall, the PSP meetings were well-attended and most, if not all, participants participated at some point during the meeting. The content, however, was primarily a description of characteristics, behaviors, risk levels, and rights restrictions of the individual that were already known to all members of the PST. The monitoring team hopes that the new PSP process will help PSTs to use their limited and valuable time together to plan for the individual's future, and to address any relevant problems the individual is facing at that time. The monitoring team, however, was impressed with the detailed and individualized discussion at Individual #379's PSP meeting regarding his weight, eating habits, and exercise. Almost every member of the PST participated somewhat in the discussion, including the individual. On the other hand, few PSP objectives for learning new skills (called training objectives) addressed relevant community living skills (also see sections F and S of this report). The number of training objectives ranged from five to seven for each individual, indicating that some work was being done to teach skills to individuals. Most disappointing, however, was that few training objectives were specially chosen to help prepare individuals who were referred for their new home and work settings. Interestingly, in the same PSP meeting in which there was much discussion about weight (Individual #379), there was little discussion of what skills might be beneficial for him to focus on (he was on the referral list). The PST asked him, "Can you think of anything else you'd like to learn?" His response was "no" and the PST left it at that. This was more an indication of the individual's inability (or lack of motivation) to prepare for his transition than the absence of his being able to benefit from community preparation skills training. In addition, some skills (PSP training objectives) were split into two objectives for different performance amounts skewing the number count of objectives. These should have been presented as a single objective.	

		Obstacles to Movement Obstacles to referral and placement were not adequately identified or addressed on an individual basis in the PSPs in any type of consistent manner across the facility. 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 to be more successful in identifying and addressing obstacles. Further, it may be that PSTs will need to differentiate between: • Reasons not to refer: these are limited and are described in the new policy on most integrated setting practices (e.g., LAR preference, individual preference, MRA not present at meeting, legal restrictions, no citizenship, severe medical requiring daily physician monitoring, severe behavioral health instability), and • Obstacles to placement: which come from the 12 obstacles chart. In the PSPs for the individuals who were not referred, obstacles that were listed had the same problems as the ones listed in the previous monitoring report (and, therefore, are not repeated here) or indicated that there were no obstacles. Thus, PSTs did not follow the state's 12 obstacles chart or differentiate between characteristics of the individuals and their need for support. As PSTs begin to define what supports are necessary to meet these needs, the discussion will likely become more centered upon what it is that the providers of community services will need to provide in order for the individual's placement to be successful, fulfilling, and long-term.	
	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.	The monitoring teams and DADS central office are working towards agreement on the specific criterion for this provision item. Once established, it will provide more specific direction to the APC and the facility regarding achieving substantial compliance. MSSLC had not yet addressed education of individuals and their families on an individual basis. The PSP template required a comment about the education of the individual and LAR, however, as exemplified in each of the written PSPs reviews, the PSP provided very little information and no details. Some PSPs described what the individual had done, whereas others described what the individual might do during the upcoming year. Some PSPs stated that living options would be presented only when they became available in the community, others only referred to possible attendance at the next provider fair. • The next step is for the PST to specifically report on (a) the activities of the previous year and (b) make a plan for the upcoming year. Even so, the facility made continued progress on this provision item. Moreover, the APC was responsive to a number of comments and recommendations from the previous monitoring report. A list of activities since 3/1/11 through 7/29/11. There were 14	Noncompliance

		entries. Eleven were CLOIP-coordinated tours of group homes (three in March, six in April, none in May, none in June, and two in July). There was one provider fair, one presentation at self-advocacy meeting, and one booth presentation by self-advocacy group at a MSSLC campus event. The 5th annual provider fair was in June 2011. Twenty-eight providers attended. A number of improvements were made to the provider fair process. This was good to see and included the following: • The APC and her staff attended MSSLC house meetings to talk with the individuals about preparing for the provider fair, such as discussing the kinds of questions to ask and the types of providers who would be attending. • The APC made a spreadsheet listing each individual and which providers he or she talked to. The spreadsheet was a great idea, however, it did not appear that the data were used to any end, either at the individual or at the facility level. • An evaluation survey was completed by a number of individuals, staff, and providers. The information was summarized. Good information was obtained and should be used for planning for the next provider fair. For example, the data immediately below could easily be graphed and presented. The provider fair attendance for the past four years 2008, 2009, 2010, and 2011 was, respectively: • Individuals: 121, 102, 90, 226 • Staff: 109, 115, 119, 198 • Family/LAR: 5, 0, 0, 1 • Providers: 33, 44, 17, 28 The local MRA created a two volume binder describing all of the providers across the state. The APC said that this was very useful to her staff and to the PSTs once an individual was referred. Moreover, it has become more common over the past six months for providers to attend PST meetings to describe their services so that PSTs could consider the provider for possible referral. There were also a number of trainings conducted with the MRA. There were not, however, any meeting minutes indicating regular contact and review topics between the APC and the MRA. The APC and PMM attended a recent self-advocacy meeting and discussed community living options. The CLOIP process continued to be implemented by the local contracted MRA. Much work had been done regarding the system of tours of community providers. Tours were listed, individual's responses were recorded by staff, and a new spreadsheet was	

		created that listed every individual at MSSLC, his or her referral status, and the number of tours that he or she had gone on. This was a very good spreadsheet/database and should be used by PSTs as well as by the facility for planning purposes. This type of spreadsheet/database may be of interest to the other SSLCs, too. As noted in the previous report, 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).	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. The facility reported that individuals were assessed by (a) PST review of assessments and documents for the individual, (b) identification of supports and barriers and the conduct of a risk assessment if an alleged offender, and (c) consideration of all of these documents before making a referral. In addition, a listing was given to the monitoring team showing every individual and whether the PST referred the individual for community. The monitoring teams have been discussing this provision item at length with DADS, especially regarding whether the determinations of professionals in their discipline-specific assessments, a well-conducted living options discussion, and similarly well-done documentation in the written PSP, would meet the requirements for this provision item. This question will be resolved by the time of the next onsite review at MSSLC.	Noncompliance
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. <u>Timeliness</u>: The 12 CLDPs reviewed indicated that they were developed in a timely manner. <u>Initiation of the CLDP</u>: Rather than waiting until right before the individual moved, the CLDP document was to be created at the time of referral with an expectation that its contents would be developed and completed over the months during which referral and placement activities occurred. The APC and the QMRP were the primary writers of the CLDP. This process had only just begun. Three of these in-process CLDPs were reviewed and, as somewhat expected, they contained only minimal information.	Noncompliance

		PST members visits to group homes: PST members were to visit group homes and be more active in supporting the individual to choose a home and provider that would best support his or her preferences and needs. This appeared to be occurring for most, but not all individuals. Post post-move monitoring PST meetings: PST meetings were to occur after every post move monitoring visit, even if there were no problematic issues. This often occurred, but was not yet occurring following every post move monitoring, according to the APC and the documents reviewed. CLDP meeting prior to move: CLDP meetings should be as efficient and useful as possible. At the CLDP meeting observed for Individual #413, a good deal of time was used to review his history and other topics that most everyone in the room was already well aware of. It would be better to use the limited time to focus upon assessments, needed supports, preferences, definitions, and identifying responsible person. The monitoring team wishes to acknowledge the director of the community provider's (D&S Residential Services) complete flexibility and willingness to do whatever the PST asked of her (e.g., data collection, activities, supports).	
	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.	Twelve completed CLDPs were reviewed by the monitoring team. The CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the MRA and community provider. The APC expected that implementation of the new CLDP policy, utilization of QA processes, and greater involvement of the PST to bring the facility closer to substantial compliance with this provision item. The actions required by the 12 CLDPs were primarily around inservicing of staff and setting up of appointments. These were important to have included, however: • The inservice requirements should also specify what the expectations were with regard to the competency of the community provider staff in implementing the programs. • Actual implementation of these supports by staff should be required. • Also see comments in T1e below. Further, the CLDPs did not describe the need for collaboration between staff at MSSLC and staff, consultants, or clinicians in the community, though there was one example of provider staff coming to the facility to be trained in food preparation and neck massages. DADS central office was conducting reviews of each of MSSLC's CDLPs. The monitoring team reviewed this feedback for 12 completed CLDPs. The comments addressed all aspects of the CLDP, were excellent, and should continue. State office should consider developing a metric to determine if facilities are making progress, that is, whether the	Noncompliance

		feedback from state office is helping to reduce errors and improve content of the CLDPs.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs indicated the staff responsible for certain actions and activities and the timelines for these actions.	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 CLDPs contained evidence of individual review and LAR review. This was also evident during observations of PSP meetings, and the CLDP meeting.	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. The APC created, and used, an assessment checklist to track submissions and updates of 13 professional discipline assessments. The checklist would be improved if instead of checkmarks, the date of the assessment was reported. This date could then be compared to the individual's move date to ensure it was no older than 45 days. The monitoring team's review of the 12 CLDPs indicated that the sets of assessments of all but one were within 45 days prior to the individual leaving the facility. In the one case, it was only a day or two older. Given, however, that the Settlement Agreement is clear about the 45-day requirement, the APC should ensure that an update is provided and dated within 45 days of the individual's move. This provision item was rated as being in substantial compliance. In order to maintain substantial compliance, the APC will need to ensure there are no exceptions to the 45-day requirement and that the checklist includes dates of the most recent assessment/update.	Substantial Compliance
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning	Twelve CLDPs were reviewed along with their attachments, typically assessments, PSPA meetings, and PSPs. There were a number of good actions evident, and some are noted below: • A variety of individuals across the entire facility were placed, including those under age 18, those with alleged offending histories, and those with multiple severe and profound disabilities. • PSPA documents indicated that numerous meetings and activities had occurred related to placement.	Noncompliance

	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.	• Many of these referrals were dormant for a year. The reason was not specified in the CLDP. It might have been because providers could not be found. The APC noted that extra efforts had been made over the past six months to identify providers for these individuals and many had been placed or were scheduled for transition. • A meeting to review assessments was held prior to CLDP meeting, this appeared to be a useful activity and helped the CLDP meeting time to be used more efficiently. • A list of standard items that needed to be in place on the day of the move was bulleted in each CLDP. This helped to reduce unnecessary additions to the list of essential and nonessential supports. • There appeared to be good involvement by PST and family members in most transitions. For example, there was consideration of multiple providers for every individual. In addition, there was consideration to have individuals move with their friends, long time housemates, or family member who was also being placed by MSSLC (in one case). • In some, but not all, cases, provider staff went to MSSLC for training, such as to learn how to prepare the diet texture and how to conduct a neck massage. • For some individuals, the support for seeing a new PCP also included a list of important topics to be shared and discussed with the PCP. On the other hand, no progress was made on the most important part of the CLDP, that is, the identification and definition of essential and nonessential supports (ENE). This was very surprising given the findings and feedback provided in the previous three monitoring reports. The monitoring team had the opportunity to discuss this issue at length with the APC and the PMM staff during the week of this onsite review. The topic was also brought up by the monitoring team during the CLDP meeting for Individual #413. The facility should also review the previous monitoring report, especially section T1e, regarding the development of an adequate listing and description of ENE supports. To that end, the following information is repeated from the previous monitoring report in hopes it will be helpful to the facility. 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 is an area where many CLDPs end up with an abundance of inservicing and appointment-setting supports, but few supports that focus on what is most important to the individual (e.g., activities, foods, relationships). The list of supports should come from the o individual's personal preferences and interests, o family members and LARs,	

		- written assessments and updates from PST members (i.e., needed services for health, safety, and skill development), - other documents, such as the PSP and PSPAs, and - 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., checklists indicating staff behavior, paperwork, items, interactions with staff) and at what criterion (e.g., twice per week). The specification of what the CLDP refers to as "evidence" will result in specific actions required by the provider so that the PMM can adequately determine whether the support was being provided. The facility might also note that it remains available, perhaps even on an on-call basis, for any questions the provider might have regarding any support. Below are comments that applied to most of the MSSLC CLDPs: - The ENE supports were almost identical across this set of 12 CLDPs. The exceptions were few, but included use of a switch, and writing in a journal. - Many of the ENE supports were for setting up of appointments or day programming or inservicing of staff (about 35%). - None of the ENE supports addressed wheelchair care and maintenance in any way. - Many ENE supports called for the item to be observed or available, but did not require the evaluation of the implementation of the support. For example, a support called for the availability of a food processor without any indication of whether or not it was used at every meal. BSPs were required to be in the individual's record, and data were sometimes required to be recorded if behavior problems occurred, but there was no requirement for documentation of implementation of the components of the BSP (e.g., reinforcement systems, teaching of replacement behaviors). Similarly, for the ENE support of 24-hour staffing, a staff schedule was to be observed, but not a record of the actual staff and hours worked. Communication dictionaries and adaptive equipment were to be observed, but there was no requirement that they be used by the individual or prompted by staff regularly or correctly.	

		Below are comments regarding individual MSSLC CLDPs. • Individual #526: He had serious medical concerns over the past year as noted on his physical assessment, but none of these were addressed in the ENE supports, such as cellulitis that resulted in hospitalization, oral ulcers, penis lesions, and an eye bruise. Sensory input was noted as being very important to him and the PST, but there was no ENE support to address it. He was working on ADL skills, but that was not to continue. Finally, he liked outdoor activities and having a blanket. These were specifically mentioned in his CLDP and PSP, but not addressed via ENE supports. • Individual #338: None of her often-mentioned preferences were included as supports to be provided. This included having finger foods to eat, having music available, going on social and community events, having her nails polished, going on nature walks, watching BET TV, and having opportunities to use her wheelchair independently. Further, she had training objectives at MSSLC for self-care skills, communication and language, and social skills that were apparently not going to be continued, but could have been. • Individual #547: There were no ENE supports to indicate that the provider would continue his active programming in social integration and self-help skills that were occurring at MSSLC. His record indicated that he was at high risk for falls, but this was not addressed. Finally, he liked to play with blocks and to earn money to be able to buy sodas and snacks. Neither was included in his list of ENE supports. • Individual #255: He had a long history of unauthorized departures, but this was not addressed. The CLDP described occurrences of him saying he didn't want to move and his refusing to sign the attendance sheet. There was no indication of what this was about or how it was addressed. A number of preferred activities and items were in the Daily Living Information Assessment, but none were carried forward to his ENE support list, such as employment, bike riding, having Chinese food, and being supported by male staff. • Individual #11: She had training objectives at MSSLC, but they were not carried forward. Nothing was included in her ENE supports regarding her favorite things, such as music, having space to move around, and bubble baths. • Individual #84: She was noted to be at risk for aspiration and choking, but there were no ENE supports to address this. Further, there was nothing supporting her strong preference for Michael Jackson music. • Individual #191: He wanted to pursue employment in landscaping, be involved in sports activities and be on a team, and he liked basketball and drawing. ENE supports for these important aspects of his life were not included. • Individual #496: He had a history of serious violent behavior. It was not addressed. Recommendations and comments from the MSSLC risk assessment were not incorporated in the list of ENE supports. Further, his need for support	

		and training around problem solving and social skills, budgeting, and reading skills were not addressed with ENE supports. The DADS state office reviewed most of the facility's CLDP and provided written feedback on all of the sections of the CLDP. The feedback was similar to what is described in this report. Moreover, the DADS reviewers provided even more detail and examples than what are included in this report. Thus, over the past year, the facility had received frequent, detailed, and consistent feedback regarding the development of an appropriate list of ENE supports from the monitoring team and from DADS central office. This provision item also requires that essential supports that are identified are in place on the day of the move. For most of the individuals, the pre-move site review was conducted by the MRA case manager and did not indicate if the essential supports were in place on the one-page form used by the MRA case manager. This was a problem, however, the new CLDP process required the facility's staff to do the pre-move site review (in addition to the MRA's review) and to assess for the presence of each essential support. Therefore, this portion of this provision is likely to be met more consistently in the future.	
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.	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. At MSSLC, and perhaps across the state, there appeared to be confusion as to whether these were to assess PSP meetings, CLDP meetings, and post move monitoring by direct observation, or if they were to assess the completed PSP document, CLDP document, and post move monitoring report. This needs to be clarified. Further, the monitoring team recommends that the APC take a close look at all three self-monitoring tools to ensure they contain the proper content, that the instructions for completion of self-monitoring are adequate, and that the criterion for scoring is valid. Proper, reliable, and valid (i.e., correct content) self-monitoring will be required if MSSLC is to achieve and maintain substantial compliance with all of section T. 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 and T1a 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 were provided in the previous monitoring report.	Noncompliance

T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this 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 not gathering 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. (A listing of one obstacle per individual was submitted to the monitoring team along with a table with the totals. The table was only for 161 individuals, most likely only those who said they wanted to move. Most of the reasons for no referral for this group were listed as behavioral or legal). The proposed statewide obstacles report was described in the previous monitoring report for MSSLC. As of the time of this review, it had not yet been issued and, therefore, the same comments from the previous monitoring report continued to be relevant and are not repeated here.	Noncompliance
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	The monitoring team was given a document titled "Community Placement Report." It was for the previous six months, 3/20/11 through 9/20/11. Although not yet included, the facility and state's intention was 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.	Substantial Compliance

	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.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any	Although this provision was rated as being in noncompliance, MSSLC was implementing the post move monitoring process and had made continued progress. Post move monitoring was conducted by the post-move monitor, Sarah Ham and the three placement specialists, Jeanette Reaves, Pamela Gonner, and Dana Cotton. (The abbreviation PMM is used in this report to refer to all four of these staff.) These staff were committed to doing post move monitoring thoroughly, correctly, and in a way that benefited the individual and the PST. The PMMs were a very hard working group and they should not consider the rating of noncompliance to be a reflection of their efforts or professionalism. Since the last onsite review, 69 post move monitoring visits had been conducted for 35 different individuals. According to the APC's tracking table, all but two were completed within the required timelines. Individuals from MSSLC were placed all over the state (i.e., not just in the local area) and the PMMs traveled to conduct post move monitoring. Of the 35 individuals, one had died prior to completion of the 90-day review and one was in jail. See T1a above for monitoring team recommendations regarding review of these types of situations.	Noncompliance

	support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	The 69 post move monitoring forms reviewed were 100% of the required post move monitoring forms required to be completed during this monitoring period. Forty-four of the 69 were reviewed by the monitoring team for 19 individuals. For most, the day and the residential sites were visited by the PMM. All used the form consistent with Appendix C, however, a new and improved form was beginning to be used. Overall, most individuals appeared to be happy and doing well in their new homes and day programs. The majority of the post move monitoring reporting was done in what is now the old format and on what is now the old form. The new form was only very recently initiated at MSSLC and was an improvement over the old form. The following comments are based on a review of the post move monitoring reports and include areas that the APC and PMMs should focus upon in order to achieve substantial compliance. • The PMMs need to clearly indicate whether or not each ENE support was in place and met the criterion set by the PST. That is, there should be an explicit "yes/no" indication. The old form did not include this; the new form does. • For many ENE supports, the PMM wrote "see attached." This was insufficient for proper completion of the post move monitoring process and reporting that can be adequately and efficiently reviewed by others (e.g., PSTs, family members, monitoring team). • Some reports, however, included two or three sentences for most ENE supports. This added to the depth of the report and should be done in all reports. • The post move monitor often looked for the presence of items and plans, and for whether or not staff inservices occurred, but not for whether the items and plans were actually being used or implemented (also see T1e above). • PMMs should require providers to summarize information for their review, when appropriate. For example, in a number of cases, it appeared that the PMM had to read pages and pages of daily staff observation notes in order to determine the status of an ENE support. Although reading these notes can be useful to the PMM, she should not have to do so in order to assess any specific ENE support. • The PMM should always also provide her overall subjective opinion about the placement. For the most part, the PMM's comments were well-written and objectively described her observations and activities. This was, of course, needed and was good to see. <u>In addition</u>, her subjective overall opinion of the home, day program, and placement should be provided. Remember, the PMM is acting as the "eyes and ears" of the PST (and the facility). The PMMs were an experienced group, had seen a variety of community sites, and were committed to making sure the individual's placement would be successful. Her opinions will be valued by the PST, will enhance the quality of the post move monitoring report, and be useful to DADS, the monitoring team, and any other reviewers. • PMMs must also look at the <u>quality</u> of the supports provided by the provider.	

		The most salient example of this being a problem was in regards to the often-included ENE for there to be a day habilitation assessment. This was reported as being met, but the actual assessment was one-page and provided no useful information for programming or treatment (in the opinion of the monitoring team). Further, there was no indication from the provider as to how this information was used. This issue should have been addressed directly by the PMM and/or brought to the attention of the PST for follow-up and/or comment. • PMMs should ensure that important topics are brought to the PST meeting that occurs following each post move monitoring visit. Most of the PST notes indicated that information was shared, but there were usually no comments from the PST. If everything was going fine, then it would not be surprising for there to be no comments (i.e., none being needed). But in cases where there are outstanding problems, the PMM must raise this and document the PST's comments and/or actions. For example, Individual #74 was having sleeping problems, counseling was not yet in place at the 90-day review for Individual #496, and Individual #232 and Individual #298 were having behavioral problems. The PMM should ensure that the PST comments on these types of issues. A good example was PMM and PST follow-up for Individual #149 regarding a weight loss issue. For Individual #84, a more complicated case, the PMM and PST met to discuss three hospitalizations, weight loss, and a change in her diet texture to pureed. This was good to see, but because this happened after her 90-day post move monitoring, no further follow-up information was provided to the monitoring team. PSTs should know that they can continue monitoring past 90 days if there is reason to do so.	
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.	The monitoring team had the opportunity to accompany the PMM and APC on a post move monitoring visit to the home of Individual #402 for the 45-day review as well as to his day habilitation program. The purpose of this visit was to see the post-move monitoring process, see the community home and day program, meet the individual, learn about transition and services, and see the status of the essential and nonessential supports. The monitoring team wishes to thank the PMM and the community agency for making arrangements for this visit to occur. Further, subsequent to the onsite review the PMM sent the completed post move monitoring form to the monitoring team. Two staff from DADS central office also attended this post-move monitoring visit. The visit was an improvement from the previous onsite review. In particular, the PMM was more detailed in her review of ENE supports and completion of the set of additional questions that are part of post move monitoring. The monitoring team recognizes that this was a particularly stressful visit, given the observation by the monitoring team, APC, and staff from DADS central office. The PMM conducted herself in a thoroughly professional manner.	Noncompliance

		Individual #402 lived in a very nice home that was built by the provider, Daybreak Services, for this individual and three others. It was wheelchair accessible, clean, and bright. The day program was also clean, bright, and there were many staff available during the time of this visit. Based on the PMM's questioning, the direct care staff at the day program and the house manager direct care staff member at the residence appeared knowledgeable about the individual. They knew about his vision problems, rumination history, bed height needs, pureed diet, the switch for his radio and fan, and abuse/neglect reporting requirements. The provider's nurse RN was also present and provided a lot of useful information. The PMM was very close to substantial compliance for this provision item. To do so, she needs to ensure that she is allowing the interviewee to fully answer the question without being provided with leading comments (e.g., about supports for vision) and that she is observing for herself when appropriate to do so rather than asking the staff (e.g., whether the residence is similar to others in the neighborhood). Further, if the PMM is unable to adequately determine the presence of a support based upon the way the evidence is described in the CLDP, she has the responsibility to look for further evidence and/or go back to the PST with questions and suggestions. For example, more observations of implementation could occur, staff could be interviewed further, the provider could be asked to initiate and complete some sort of checklist indicating staff implementation (e.g., use of switch, use of communication dictionary).	
T3	**Alleged Offenders -** The provisions of this Section T do not 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.	This item does not receive a rating.	

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 the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	Three individuals were discharged properly as per the requirements of this provision item as evidenced by documents submitted to the monitoring team. The individuals and the reason for discharge are below: • Individual #327: declining health, transferred to other SSLC. • Individual #182: transferred to state hospital. • Individual #212: ineligible for further services.	Substantial Compliance

Recommendations:

1. Update facility policies to make them in line with the new state policy, and subject the facility-specific policies to the requirements of section V2 (T1b).

2. Implement a process of review for each individual (who does not have an LAR who is opposed to placement) who has requested placement, but has not been referred (e.g., Placement Appeal) (T1a).

3. Identify those individuals who would have been referred except for the preference choice of the LAR; this list should include not only those who themselves requested referral, but those individuals who themselves cannot express a preference but whose PSTs would otherwise have referred. Add this list to the Community Placement Report (T1a, T1h).

4. Ensure that professional determinations are explicitly included in the PSP meeting, and that these professional determinations are clearly indicated in the PSP document. Professional determination is separate from both the preference of the individual, the LAR, and the opinion of the PST as a whole (T1a, T1b1).

5. Do a thorough review of every case when an individual who was placed in the community has died, been jailed, admitted to a psychiatric facility, or was returned to the facility. Consider doing the same for any rescinded referrals, however, due to the frequent changes in individual's referral status at MSSLC, doing this review for every rescinded referral may not be possible. The thorough review by the APC and her staff should be of each failed placement as if it were a "sentinel event" for the admissions and placement department (T1a).

6. Ensure that PST members see the homes and day programs that are being considered for individuals who are referred (T1c1, T2b).

7. Implement an effective and efficient LOD; ensure that there is collaboration between the consultants who are developing the next revision of the PSP process and the central office coordinator for most integrated setting practices (T1b1).

8. Create more consistency in amount of information included in the LOD sub-section of the written PSP. Consider the comments and examples presented above (T1b1).

9. Chose training objectives that will help individuals who are referred learn relevant skills (T1b1).

10. Identify and address obstacles to referral and to placement at an individual level (T1b1).

11. Identify and address obstacles to referral and placement across all individuals at the facility by conducting a comprehensive assessment and analyzing the information (T1g).

12. Assess implementation instructions, content, and scoring criterion for the three self-assessment tools being used for this provision; implement them in a reliable and consistent manner; and utilize the results (T1b1).

13. In the PSP, describe what activities were taken over the past year, and what activities are to be taken during the upcoming year, to educate the individual and/or his or her LAR regarding community placement (T1b2).

14. Use the data collected from the provider fair and community tour program (T1b2).

15. Summarize and graph all relevant data from the Admission and Placement department's activities (T1a, T1f).

16. Include Admission and Placement data in the facility's QA program (T1a, T1f).

17. Consider doing a more detailed weekly report from the APC for senior management (T1a).

18. Address the many comments in T1e above regarding the determination and definition of essential and nonessential supports, including, but not limited to:
    a. Ensure essential and nonessential supports specifically include the individual's most important preferences and the most important supports and services noted by the PST (T1e).
    b. When an inservice is listed as a support, it should also include competency outcomes (T1e).
    c. The content of inservices and appointments should be considered to be included in the list of essential or nonessential supports (T1e).
    d. Actual implementation of supports should be included, not just the presence of items or the inservicing of staff.
    e. Include a crisis plan for those individuals for whom that might be appropriate (T1e).
    f. Include supports to be provided during work/day programming rather than only indicating enrollment in a program (T1e).

19. Pre-move site visits should ensure that all essential supports are in place (T1e).

20. Address each of the bulleted items in the monitoring report section T2a above (T2a).

21. Improve the interview and post move monitoring onsite components as describe in T2b (T2b).

22. DADS CLDP reviews might be done at various stages of CLDP development, not only immediately prior to the move date. In addition, consider creating a metric to measure the quality of the CLDPs (T1c1).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DRAFT DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o MSSLC Plan of Improvement updated 8/2/11 o Determination For Need For Guardian Priority Tool o Request for Guardian/Advocate Form o Advocate or Guardian Request List o PSPs for: • Individual #461, Individual #108, Individual #244, Individual #592, Individual #570, Individual #521, Individual #42, Individual #359, Individual #227, Individual #39, Individual #331, Individual #242, Individual #115, Individual #483, Individual #588, Individual #319, Individual #376, Individual #6, Individual #422, Individual #264, and Individual #126 Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Valerie McGuire, QDDP Director o Terri Moon, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Daily Incident Management Review Team Meeting 9/19/11 o Longhorn Daily Unit Meeting 9/21/11 o Restraint Reduction Committee Meeting 9/22/11 o Human Rights Committee Meeting 9/20/11 o Quarterly PSP meeting for Individual #128 o Annual PSP meetings for Individual #360 and Individual #123
	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. It was updated on 9/8/11. In addition, during the onsite review, the HRO reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending.

	The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility assigned a noncompliance rating to both of the provision items in section U. It was unclear from a review of the POI how MSSLC came to this self-rating. Nevertheless, the monitoring team was in agreement with these self-ratings. The facility was still waiting on approval of the state policy regarding consent and guardianship.
	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. Some positive steps that the facility had taken in regards to consent and guardianship issues included: • A new Human Rights Officer had been hired and designated as the responsible person for overseeing compliance with Section U requirements. • The facility had updated a list of individuals and their guardianship status. • Information on guardianship was mailed to families. • The Human Rights Committee continued to meet and review all restrictions of rights. • The facility had provided training to the Self Advocacy group comprised of individuals residing at the facility. • The Human Rights Officer had made contact with advocacy and guardianship agencies in the area. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. While the facility maintained a list of individuals needing an LAR, the list was not prioritized and not all PSTs were adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. The facility reported little activity or planning to solicit guardians for those determined to be in need. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. The facility had an active Human Rights Committee in place to review restrictions requested by the PST. Some PSTs were not holding discussions around the need for guardians in reference to the capacity for individuals to make decisions and give consent.

#	Provision	Assessment of Status	Compliance
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 a 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 planned to take action in these areas once the policy is finalized. At the March 2011 monitoring visit, the facility had a list of eight individuals who had been referred for guardianship and four referred for advocates. A list provided to the monitoring team at this visit indicated that two individuals were referred for guardianship and 16 for an advocate. Both individuals referred for guardianship were new referrals. The eight individuals previously referred were no longer on the referral list and guardianship had not been obtained. An application for guardianship to Friends for Life, a community guardianship agency, was completed for one of the individuals on the list. PSTs were not assessing individual's ability to make informed decisions. There was no evidence in any of the PSPs reviewed that teams were discussing the need for guardianship in relation to the individual's ability to make decisions or give informed consent. PSTs need to hold more thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. The facility was not yet in compliance with this provision.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current	MSSLC was awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before developing facility-specific policies to address consent and guardianship. The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. The facility did have some rights protections in place including an assistant independent 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 rights for individuals at MSSLC. The monitoring team encourages the facility to continue to explore new ways to support	Noncompliance

#	Provision	Assessment of Status	Compliance
	LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	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. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR (U1).

2. 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 (U2).

3. Continue to teach individuals to problem-solve, make decisions, and advocate for themselves (U1, U2).

4. 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 (U2).

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o MSSLC policy, Recordkeeping Practices, Administrative Services-6, dated 3/10/11 o Organizational chart, 9/1/11 o MSSLC policy lists, three policy books, July 2011 and August 2011 o List of typical meetings that occurred at MSSLC o MSSLC POI, 9/8/11 o MSSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/19/11 o List of all staff responsible for management of unified records o Tables of contents active records and individual notebooks, updated 8/24/11 o Table of contents for the master record, updated 8/24/11 o List of individuals chosen for recordkeeping audits, 5 to 10 each month, February 2011 - July 2011 o 16 completed audits of active record and individual notebooks, July 2011 and August 2011; included the state self-assessment form and the facility's table of contents/guidelines form o 21 completed audits of individual notebooks using the facility's table of contents completed by the home record clerks, July 2011 and August 2011 o Various lists of findings of audits, emails to and from responsible managers and clinicians, and highlighted entries indicating status of corrections o URC audit tracker lists, March 2011 to May 2011 o URC monthly progress note tracking sheet forms and summarized data o Results of two V4 interviews o Listing of nursing active record subsection contents o Various documents regarding the MSSLC workgroup on individual notebooks, including information obtained from other SSLCs o MSSLC URC comments regarding a single record room per unit, undated o Documentation regarding purchase of new durable individual notebook binders o A spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, dated 9/1/11 o Email regarding state office expectations for facility-specific policies, from central office SSLC director of operations, Donna Jesse, 3/15/11 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 #119, Individual #10, Individual #550, Individual #89, Individual #221, Individual #379, Individual #413, Individual #369

	Interviews and Meetings Held: o Elaine Schulte, Director of Client Records o Sherrie Price and Misty Samuels, Unified Records Coordinators o Home records clerks and administrative assistant (six) o Numerous staff and clinicians during observations in residences Observations Conducted: o Records storage areas in residences o Overflow and master records storage area o QAQI Council meeting, 9/22/11 o PET I meeting, 9/21/11
	Facility Self-Assessment: MSSLC submitted its self-assessment, called the POI. It was updated on 9/8/11. In addition, during the onsite review, the Director of Client Records and the Unified Records Coordinators reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the director of client records wrote a sentence or two about what tasks were completed. Some entries were many months old. The monitoring team, however, would prefer to have an understanding of the self-assessment process used by the recordkeeping department. For instance, 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. Further, the POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The director of client records self-rated the facility as being in noncompliance with all four provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI should be written to guide the department in achieving substantial compliance. Five action steps were included in the POI and all were relevant to improving recordkeeping practices, however, they did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). A set of actions, such as those described in this monitoring report, should be set out as actions. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation of an action, but a timeline that will indicate the stable and regular implementation of each of these actions.

	Summary of Monitor's Assessment: MSSLC demonstrated continued progress. The department director and the two URCs continued to be very serious about their jobs and had responded to many of the recommendations and comments from the previous monitoring report. The monitoring team had the opportunity to meet with the group of five unit record clerks and the department's administrative assistant. Their efforts were also contributing to MSSLC's continued progress. The requirement to have, and manage, state and facility-policies was not yet being done at MSSLC. The DADS statewide policy remained in effect. Any policies in MSSLC's set of facility-specific policies that apply to recordkeeping should be updated, approved, and implemented, or if not being used, removed. The URCs had begun to summarize and graph data from some of their activities. Graphs indicated the number of corrections required after each monthly audit of the active records, and the number of corrections that were still not completed after a two-month "window" that was allowed for corrections to be made. The active records were neat and organized. Many documents, however, were not submitted for filing or were submitted late. Active record volumes were often missing from their assigned location, were not signed out by staff, and disappeared and reappeared. Other documents were sometimes missing from the active record, that is, documents were found to be absent, such as SPOs. Legible content and signatures, and inclusion of credentials needed to be improved for the IPNs. MSSLC had not yet made an active decision regarding how to proceed with the individual notebooks. This was surprising given the serious problems with the individual notebook system at MSSLC, as detailed in the previous monitoring report. Overall, it appeared it was difficult keeping the contents current, many items disappeared or were torn out, and the books required a great deal of attention and time from the record clerks every day. It is likely that a different system will be needed for the three forensic units as compared to the other two units. MSSLC had master records and a checklist table of contents. Many items on the list were not available. The next step is for the facility to determine what to do about the many items that were missing (e.g., determination of mental retardation, birth certificate). The URCs conducted reviews of at least five records each month. They did not, however, include the master record in those reviews. Also, many of the monthly audits did not include the individual notebook because it was often not available at the time of day the URC conducted her review. Overall, the reviews that were completed were done so in a consistent manner. Two forms were completed for each review. One was the statewide monitoring tool. The other was the table of contents for the active record and individual notebook. There was a consistency in the issues and problems identified by the URCs. Information from monthly summaries of results should be used for action planning, documentation in the medical consultation sections needed to be informed by the medical director's listing of consultations, and

	the guidelines-followed column of the table of contents form should be marked. A few of the statewide forms indicated that there was falsification of records. This should be thoroughly examined. All needed corrections were entered into a table called the Audit Tracker. The URCs used this listing to follow-up on all of the corrections. They did this across a two-month period following each review. It was a reasonable way to manage the status of corrections. To address the facility's use of the unified records to make treatment and care decisions, the recordkeeping staff had done two brief interviews of a PST member. More activities will need to be undertaken. Direction will likely be provided by state office in the near future.

#	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.	MSSLC demonstrated continued progress with this provision item. The director of client records and the Unified Records Coordinators (URC) continued to lead the facility towards substantial compliance, which is likely to be obtained for this provision item in the near future. They also described their recent increased inclusion in facility management activities and plans and processes to address the Settlement Agreement. The DADS statewide policy remained in effect. In addition, the director of client records reported that the facility was also following a facility-specific policy, Adm-06, which was described in the previous monitoring report. At that time, two other recordkeeping-related policies were also being revised. No update on these policies, however, was reported. This should be corrected for the next monitoring review, that is, any policies in MSSLC's set of facility-specific policies that apply to recordkeeping should be updated, approved, and implemented, or if not being used, removed. The recordkeeping staff were responsive to a number of the recommendations and comments from the previous onsite review. Moreover, recordkeeping had become a topic of active discussion in the QAQI Council and PET meetings observed. For example, • The large nursing section of the active record was sub-divided with blue and green sheets of paper. In some of the active records, these sub-dividers were in plastic sheets that extended beyond the width of the other pages, making it much easier to use the sub-dividers. This should be done for all active records, unless the nursing department does not prefer it to be that way. • The URCs had begun to summarize and graph data from some of their activities. Graphs indicated the number of corrections required after each monthly audit of the active records, and the number of corrections that were still not completed after a two-month "window" that was allowed for corrections to be made. The monitoring team and the URCs discussed ways to make the graphs as clear and simple as possible. Further, the data should also be presented unit-by-unit as	Noncompliance

#	Provision	Assessment of Status	Compliance
		well as for the facility as a whole. • A new system of requiring the home clerks to track the submission of monthly progress notes was initiated. The results of this tracking were also graphed (for three of the five units so far). The monitoring team and the URCs also discussed this graph and ways to improve its clarity, such as making one data point per month, so that they can show trends for each unit and for the facility as a whole. • The director of home life and training reviewed a proposed five-page observation note format. Good discussion occurred at the QAQI Council meeting (e.g., director of psychology, medical director, director of habilitation, two unit directors, interim assistant director of programs). It was to be piloted at two or three homes. The URCs will need to determine how to incorporate this new form into their monthly auditing process. • Other topics were discussed at QAQI Council and PET meetings, such as the filing the APLs alongside the IPNs (raised by the medical director), putting observation notes into the IPNs, and centralizing of the record rooms into one room in each unit (raised by assistant directors). o In the opinion of the monitoring team, staff observation notes should continue to be separate from the IPNs, that is, they should <u>not</u> be combined. o Creating a single records room per unit would be a major change to the facility's operations, however, it should be thoughtfully considered due to potential benefits. The URCs created a short three-page document detailing a proposal for piloting as well as a consideration of pros and cons. This should be fully explored. <u>Active records</u> The active records reviewed by the monitoring team were neat and organized. It was easy to find where items were supposed to be located. Active records and individual notebooks were present during PST meetings (e.g., Individual #379, Individual #413, Individual #369). Continued progress in the management of the active records was occurring, however, there were a number of issues that needed to be addressed, as evidenced by the monitoring team's review of the records, monitoring team discussion with record clerks, topics at senior management meetings, and the department's own self-monitoring and audits. The recordkeeping staff was aware of all of these. • Many documents were not submitted for filing or were submitted late. This affected the facility's performance in most of the provisions of the Settlement Agreement. The problem was more complicated than the mere failure of professional staff to submit documentation. QMRPs and clinicians had many competing activities and documents (e.g., PSPs, BSPs, QMRP reviews, assessments) were not always completed on time.	

#	Provision	Assessment of Status	Compliance
		○ Data regarding what was labeled "delinquent documentation" were presented and reviewed during the PET meeting. As a result, much discussion occurred, again demonstrating that the inclusion of data sets the occasion for management to engage in active discussion. • Active record volumes were often missing from their assigned location, were not signed out by staff, and disappeared and reappeared. • Documents were sometimes missing from the active record, that is, documents were found to be absent, such as SPOs. • Legible content and signatures, and inclusion of credentials needed to be improved for the IPNs. This issue had not gone undetected; the URCs noted it in every record audit. • In most active records, there was no social history and there were few or no consents. This was not in line with state policy. If there are reasons for a difference at MSSLC, it should be outlined in facility-specific policy and approved by state office. • The URCs need to use the medical department's list of medical consultations in order to determine what medical consultation documentation should be in each active record because these varied from individual to individual (e.g., cardiac, podiatry, vision). This was recommended during the last onsite review, but had not been implemented. <u>Individual notebooks</u> The DADS central office coordinator for recordkeeping practices sent a request for each SSLC to pick one of four individual notebook options. MSSLC had not yet made an active decision regarding how to proceed with their management of individual notebooks. This was surprising given the serious problems with the individual notebook system at MSSLC, as detailed in the previous monitoring report. MSSLC needs to address this by the next onsite review. That being said, MSSLC had taken some action since the last review by forming two committees to look at this issue. The director of client records also contacted a number of other facilities to learn how they were handling their individual notebooks. A lot of good information was obtained and some of it might even be useful to state office. All of this activity, however, had not led to any resolution or action at MSSLC. Even so, individual notebooks were in place and available for each individual. Across the facility, they varied in condition, indicating that they were being used by staff, however, the problems noted in the previous monitoring report remained, especially for the homes in the facility's forensic division. Overall, it appeared it was difficult keeping the contents current, many items disappeared or were torn out, and the books required a great deal of	

#	Provision	Assessment of Status	Compliance
		attention and time from the record clerks every day. It is likely that a different system will be needed for the three forensic units as compared to the other two units. <u>Master records</u> MSSLC had master records and a checklist table of contents. It was evident that many items on the list were not available. The next step is for the facility to determine what to do about the many items that were missing (e.g., determination of mental retardation, birth certificate). The recordkeeping staff should have some sort of procedure or rubric to follow so that they are ensuring that they are doing follow-up on any documents that should be located. Perhaps state office can provide some guidance. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review. <u>Record Clerks</u> The monitoring team had the opportunity to meet with the group of five unit record clerks and the department's administrative assistant. The facility was fortunate to have such a dedicated and experienced group. Their efforts were also contributing to MSSLC's continued progress. The record clerks had many responsibilities, including filing all kinds of documents, purging the records, mending active records and individual notebooks, and ensuring blank forms were available for all staff and clinicians. Their input and opinions may be helpful to MSSLC as it moves forward to meeting substantial compliance with this provision item.	
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.	MSSLC had a single spreadsheet that indicated the status of state policies and the status of facility-specific policies. This was maintained by the facility director's administrative assistant. Not all policies were yet in place, though continued progress was evident. At the time of the last onsite review, the facility had a more detailed listing of facility-specific policies. The current spreadsheet did not appear sufficient to guide the MSSLC in meeting the facility-specific requirements of this provision item. The monitoring team was very pleased to see that state office was requiring an organized and systematic way of managing facility-specific policies, that is, state office: • Required a facility-specific policy (or policies) for every Settlement Agreement provision • Required each facility-specific policy to be in line with the contents of the state policy • Required the facility to submit each facility-specific policy for approval	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Provided feedback on the content of each facility-specific policy • Detailed these expectations in an email memo from the DADS SSLC director of operations, dated 3/15/11. These specific steps were not yet being implemented at MSSLC for the facility-specific policies.	
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 URCs conducted reviews of at least five records each month (i.e., five in June 2011, 10 in July 2011, six in August 2011). They did not, however, include the master record in those reviews. They should begin to include the master record now, rather than waiting for state office to instruct them to do so. Overall, the reviews were done in a consistent manner. Two forms were completed for each review. One was the statewide monitoring tool for provision V. The other was the table of contents for the active record and individual notebook. The URCs used the table of contents review to indicate whether items were or were not in the active record or individual notebook. Then, they used this information to complete the statewide form. Further, any detailed comments about the quality of the contents of the records and any needed corrections were: • entered in the comments section of the statewide form, • counted for the URC's data graph, and • copied into the audit tracker (see below) Across 16 reviews (statewide forms and table of contents forms) there was a consistency in the issues and problems identified by the URCs. The needed corrections were worded succinctly. Further, the URCs summarized their findings into a well-written monthly summary-of-concerns two-page note. The monitoring team wishes to raise other important points regarding these reviews: • It did not appear that information from the monthly summary document was used in any way (e.g., for action planning, as feedback to QAQI Council). • Documentation in the medical consultation sections needed to be informed by the medical director's listing of consultations (also noted in V1 above). • A few of the statewide forms indicated that there was falsification of records (Individual #508, Individual #194), however, the monitoring team could not tell from the comments what it was that appeared to be falsified. Falsification of records is serious and should be thoroughly examined. The findings might result in disciplinary action and/or an investigation. • The table of contents review also contained a column to indicate if the guidelines for each item were also being followed (in addition to whether or not the document was present). This column should also be scored by the URCs.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Many of the monthly audits did not include the individual notebook because the individual notebook was often not available at the time of day the URC conducted her review. This should be corrected, that is, the URC audit needs to include the individual notebook. To somewhat address this, each unit record clerk conducted a review of one of her individual notebooks each week. The results of 21 of these reviews were given to the monitoring team. The results, however, were not summarized, it was unclear if any follow-up occurred, and phrases such as "not in chart" were not explained. All needed corrections were entered into a table called the Audit Tracker. The URCs used this listing to follow-up on all of the corrections. They did this across a two-month period following each review. It was a reasonable way to manage the status of corrections. The data were then included in the department's data graphs. In summary, the URCs had made continued progress towards substantial compliance with this provision item. They will need to include the master record, ensure that they are including at least five individual notebooks in their reviews, and address the other points and concerns noted above.	
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.	Continued progress was demonstrated by the recordkeeping staff, however, more work will need to be done to determine the full set of activities the facility needs to engage in to demonstrate that records are being used as required by this provision item. Recently, the monitoring teams presented, to DADS and DOJ, a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item. The recordkeeping staff had implemented one process towards this end. They recently began to conduct a post-PSP interview with one PST member using the new questionnaire form developed by central office (two had been completed at the time of this review). The results of these were not summarized or used by the facility in any way. Further, only talking with one PST member each month might not provide enough information for any generalizations to be made about the use of records. 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. • Active records and individual notebooks were present at PST meetings, such as annual PSPs, PSPAs, and CLDPs (e.g., Individual #379, Individual #413, Individual #369). • The staff reported that the individual books were helpful. The monitoring team	Noncompliance

#	Provision	Assessment of Status	Compliance
		observed direct care staff using the individual books. • In all four observed psychiatric clinic encounters, the individual's record was available and the physician was actively reviewing documents. Information was available to the physician (e.g., laboratory data, most recent MOSES/DISCUS). • Since the prior monitoring review, the legibility of nurses' notes, signatures, and credentials had improved. • There continued, however, to be problems with nurses o writing over incorrect information and obliterating entries in the IPNs versus properly indicating errors with a line through the incorrect entry and the author's initials, o documentation on the margins of the page versus staring a new IPN page, o notes, on the same page, that were not in chronological order o notes that were uninformative, cryptic phrases that failed to constitute an assessment or evaluation of any sort. For example, individuals were noted to have eaten with "no problems." Others who had problems with skin integrity were noted as "having less pimples than last quarter." • The consent forms must be reviewed to include the necessary components of an informed consent process. • The psychiatry QPMR form did not allow the psychiatrist to adequately document the content of the consult. The actual record keeping of the psychiatric consultation should be reviewed.	

Recommendations:

1. Resolve the status of facility-specific policies for recordkeeping (V1).
2. Standardize the format of the nursing sub-dividers (V1).
3. Determine what to do about having a single records room for each unit (V1).
4. Correct missing/late documentation for the active records (V1).
5. Determine what to do about missing social histories and consents (V1).
6. Determine what medical consultation documentation should be in each active record (V1, V3).
7. Determine what to do about the individual notebooks (V1).

8. Manage the status of state and facility policies for each of the provisions of the Settlement Agreement. Consider making a second spreadsheet that details MSSLC's facility-specific policies (V2).
9. Follow the steps outlined by DADS central office regarding facility-specific policies (V2).
10. Include the master record in the monthly audits (V3).
11. Determine what to do about items that are missing from the master record (V1).
12. URCs must conduct at least five individual notebook reviews (V3).
13. Complete the guidelines-followed column in the table of contents review (V3).
14. Use the monthly summary for action planning (V3).
15. Follow-up on any identified falsification of records (V3).
16. Update the format of the graphs of (a) corrections and outstanding corrections, and (b) missing/late documentation (V1).
17. Implement all procedures to address V4 when disseminated from state office (V4).
18. Summarize and use the information collected from the post-PSP meeting PST interviews (V4).
19. The consent forms must be reviewed to include the necessary components of an informed consent process. This category involves medical legal documentation that is part of the necessary record keeping practices of the facility (V4, also section J14).

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
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACP	Acute Care Plan
ADA	American Dental Association
ADA	American Diabetes Association
ADA	Americans with Disabilities Act
ADE	Adverse Drug Event
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AICD	Automated Implantable Cardioverter Defibrillator
AIMS	Abnormal Involuntary Movement Scale
ALT	Alanine Aminotransferase
AMA	Annual Medical Assessment
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
ASA	Aspirin
ASAP	As Soon As Possible
AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Active Treatment Provider

AUD	Audiology
BBS	Bilateral Breath Sounds
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLS	Basic Life Support
BM	Bowel Movement
BMD	Bone Mass Density
BMI	Body Mass Index
BMP	Basic Metabolic Panel
BON	Board of Nursing
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
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CC	Campus Coordinator
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCP	Code of Criminal Procedure
CCR	Coordinator of Consumer Records
CD	Computer Disk
CDC	Centers for Disease Control
CDDN	Certified Developmental Disabilities Nurse
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process

CMax	Concentration Maximum
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CMS	Circulation, Movement, and Sensation
CNE	Chief Nurse Executive
CNS	Central Nervous System
COPD	Chronic obstructive pulmonary disease
COTA	Certified Occupational Therapy Assistant
CPEU	Continuing Professional Education Units
CPK	Creatinine Kinase
CPR	Cardio Pulmonary Resuscitation
CPS	Child Protective Services
CR	Controlled Release
CRA	Comprehensive Residential Assessment
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTA	Clear To Auscultation
CTD	Competency Training and Development
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
CXR	Chest X-ray
D&C	Dilation and Curettage
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Texas Department of Assistive and Rehabilitative Services
DBT	Dialectical Behavior Therapy
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DD	Developmental Disabilities
DDS	Doctor of Dental Surgery
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DIMM	Daily Incident Management Meeting
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM	Diabetes Management
DME	Durable Medical Equipment
DNR	Do Not Resuscitate
DNR	Do Not Return
DO	Disorder
DO	Doctor of Osteopathy

DOJ	U.S. Department of Justice
DPT	Doctorate, Physical Therapy
DR & DT	Date Recorded and Date Transcribed
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EBWR	Estimated Body Weight Range
EEG	Electroencephalogram
EES	erythromycin ethyl succinate
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank
EMR	Employee Misconduct Registry
EMS	Emergency Medical Service
ENE	Essential Nonessential
ENT	Ear, Nose, Throat
EPISD	El Paso Independent School District
EPS	Extra Pyramidal Syndrome
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
ER	Extended Release
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FNP	Family Nurse Practitioner
FOB	Fecal Occult Blood
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FTF	Face to Face
FU	Follow-up
FX	Fracture
FY	Fiscal Year
G-tube	Gastrostomy Tube
GAD	Generalized Anxiety Disorder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal

GM	Gram
GYN	Gynecology
H	Hour
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide
HCTZ KCL	Hydrochlorothiazide Potassium Chloride
HDL	High Density Lipoprotein
HHN	Hand Held Nebulizer
HHSC	Texas Health and Human Services Commission
HIP	Health Information Program
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HMP	Health Maintenance Plan
HOB	Head of Bed
HPV	Human papillomavirus
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HRO	Human Rights Officer
HRT	Hormone Replacement Therapy
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
i.e.	id est (In Other Words)
IAR	Integrated Active Record
IC	Infection Control
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
IDT	Interdisciplinary Team
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
IMRT	Incident Management Review Team
IMT	Incident Management Team
IOA	Inter Observer Agreement

IPE	Initial Psychiatric Evaluation
IPN	Integrated Progress Note
ISP	Individual Support Plan
IT	Information Technology
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KUB	Kidney, Ureter, Bladder
L	Left
L	Liter
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOD	Living Options Discussion
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAP	Multi-sensory Adaptive Program
MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MCG	Microgram
MCP	Medical Care Provider
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MED	Masters, Education
Meq	Milli-equivalent
MeqL	Milli-equivalent per liter
MERC	Medication Error Review Committee
MG	Milligrams
MH	Mental Health

MI	Myocardial Infarction
MISD	Mexia Independent School District
MISYS	A System for Laboratory Inquiry
ML	Milliliter
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Associate
MRA	Mental Retardation Authority
MRC	Medical Records Coordinator
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphyloccus aureus
MS	Master of Science
MSN	Master of Science, Nursing
MSPT	Master of Science, Physical Therapy
MSSLC	Mexia State Supported Living Center
MVI	Multi Vitamin
N/V	No Vomiting
NA	Not Applicable
NA	Sodium
NAN	No Action Necessary
NANDA	North American Nursing Diagnosis Association
NAR	Nurse Aide Registry
NC	Nasal Cannula
NCC	No Client Contact
NCP	Nursing Care Plan
NEO	New Employee Orientation
NGA	New Generation Antipsychotics
NL	Nutritional
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
O2SAT	Oxygen Saturation
OBS	Occupational Therapy, Behavior, Speech
OCD	Obsessive Compulsive Disorder
ODD	Oppositional Defiant Disorder
OIG	Office of Inspector General
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate

OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
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
PDD	Pervasive Developmental Disorder
PEG	Percutaneous Endoscopic Gastrostomy
PEPRC	Psychology External Peer Review Committee
PERL	Pupils Equal and Reactive to Light
PET	Performance Evaluation Team
PFA	Personal Focus Assessment
PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
Pharm.D.	Doctorate, Pharmacy
PIC	Performance Improvement Council
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PKU	Phenylketonuria
PLTS	Platelets
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 Oximetry
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)
PPI	Protein Pump Inhibitor
PR	Peer Review
PRC	Pre Peer Review Committee
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	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
PTPTT	Prothrombin Time/Partial Prothrombin Time
PTSD	Post Traumatic Stress Disorder
PTT	Partial Thromboplastin Time
PVD	Peripheral Vascular Disease
Q	At
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council
QDDP	Qualified Developmental Disabilities Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QHS	quaque hora somni (at bedtime)
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner
RPH	Registered Pharmacist
RPO	Review of Physician Orders
RR	Respiratory Rate
RT	Respiration Therapist
RTA	Rehabilitation Therapy Assessment
RTC	Return to clinic
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SAP	Skill Acquisition Plan
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SETT	Student, Environments, Tasks, and Tools
SGSSLC	San Angelo State Supported Living Center

SIADH	Syndrome of Inappropriate Anti-Diuretic Hormone Hypersecretion
SIB	Self-injurious Behavior
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPCI	Safety Plan for Crisis Intervention
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
STAT	Immediately (statim)
STD	Sexually Transmitted Disease
STEPP	Specialized Teaching and Education for People with Paraphilias
STOP	Specialized Treatment of Pedophilias
T	Temperature
TAR	Treatment Administration Record
TB	Tuberculosis
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TED	Thrombo Embolic Deterrent
TG	Triglyceride
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TMax	Time Maximum
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TSICP	Texas Society of Infection Control & Prevention
TT	Treatment Therapist
UA	Urinalysis
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
URC	Unified Records Coordinator
US	United States
USPSTF	United States Preventive Services Task Force
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VPA	Valproic Acid

VS	Vital Signs
WBC	White Blood Count
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old