United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

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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 (ICFMR) 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 onsite. 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 onsite, 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, Interdisciplinary Team (IDT) 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 from the parties to protect the confidentiality of each individual.

Substantial Compliance Ratings and Progress

Across the state's 13 facilities, there was variability in the progress being made by each facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation, of the parties who crafted the Settlement Agreement was for there to be systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report for detail regarding the facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity; some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, provision item L.1 addresses the total system of the provision of medical care at the facility. Contrast this with provision item T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the facility will obtain substantial compliance with 25% of the

provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement because of the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the facility (as was the intent of the parties).

Executive Summary

First, 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 new facility director, Mike Davis, was extremely supportive of the monitoring team's activities throughout the week of the onsite review. The Settlement Agreement Coordinator, Etta Jenkins, once again did an outstanding job in helping the monitoring team with its activities all week long, as well as the weeks prior to and after the onsite week. She was extremely knowledgeable about the facility and that experience was helpful to the monitoring team.

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, below are comments on a few general topics regarding service operations at the facility and one item about this report.

- New management team: MSSLC had a new facility director, new ADOP, new ADOA, and was soon to have a new QA director. There was much optimism across management staff and across campus in moving the facility forward in treatment, intervention, support, and service, as well as towards substantial compliance with the Settlement Agreement. The monitoring team shares that optimism.

- Self-assessment: This was MSSLC's first try at the new self-assessment process. Overall, there was good progress. Most discipline and Settlement Agreement provision leaders spent a good deal of time talking with the monitoring team about how to make the self-assessment process valid, meaningful, and in line with the Settlement Agreement requirements. Most challenging will be developing a set of self-assessment activities for each provision that separates the fine distinction between activities to engage in to meet the requirements of the Settlement Agreement versus activities to engage in to assess whether substantial compliance is being met.

More detail is provided below in each section of this report for each of the provisions of the Settlement Agreement.

- Peer to peer aggression: The facility and the monitoring team both noted an apparent increase in the frequency, intensity, and seriousness of aggressive acts between individuals. Addressing this will be a cross-facility activity that will require, at a minimum, oversight by the facility director and the QA department.

- New ISP Process: MSSLC had not yet received state office training on initiating the new ISP process. Once done, further progress is likely to be seen, especially in sections F and T.

- ISP terminology: DADS and the SSLCs changed the wording of many documents, meetings, and processes to Individual Support Plan (ISP). This was a change from the previous Personal Support Plan (PSP). Also, the Personal Support Team (PST) name was changed to the Interdisciplinary Team (IDT). This report uses the new terminology and refers to all documents with the new terminology.

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

- Between 9/1/11 and 2/29/12, there were 226 restraints used for crisis intervention. This was a 31% decrease from the 327 restraints that occurred in the previous six month period and a 53% decrease from the 483 restraint incidents during the same six month period of the previous year. Of these 226 restraints, 214 were physical restraints and 12 were chemical restraints.
- The monitoring team found that some mechanical restraints that were being used to address self-injurious behavior were classified as medical restraints and, therefore, were not routinely reviewed by IDTs, addressed in behavior support plans, or reported in terms of restraints at the facility. These included mittens and helmets. Recently, a statewide plan was put in place to address these types of situations.
- There were 17 incidents of restraint used for medical and/or dental treatment. This was a 61% decrease compared to the time of the last monitoring team visit.
- Actions taken since the last onsite review included that psychology staff were completing the statewide monitoring tool monthly; all restraints were being reviewed in the daily clinical services meeting, daily unit meeting, and Incident Review Team meeting; and a spreadsheet was developed to track restraint reviews and

resulting recommendations. Further, the Behavior Support Committee was using a checklist to review ISPAs for individuals with more than three restraints to determine if compliance was met with section C7 requirements.

Abuse, Neglect, and Incident Management

- DFPS confirmed 22 cases of physical abuse, one case of sexual abuse, three cases of emotional/verbal abuse, and six cases of neglect during the previous six months. There were investigations of 1222 allegations conducted by DFPS at the facility during this period. A large number of these (366) were deemed to be spurious allegations by DFPS investigators.
- A list of all serious incidents investigated by the facility during the previous six months was requested by the monitoring team. The facility did not provide that information. In order to address trends in incidents, the facility will need to develop a system to track and trend all incidents.
- There were a total of 1386 injuries reported between 8/1/11 and 2/27/12. These 1386 injuries included 36 serious injuries resulting in fractures or sutures. A large number of injuries were resulting from behavioral issues, including peer-to-peer aggression.
- Some positive steps taken to address the incidents and their management at MSSLC were:
    - Creation of a database to maintain and track disciplinary action related to allegations.
    - A revision of the employee abuse, neglect, and exploitation competency test.
    - Inservice for all QDDPs on providing information/educating LARs, family members, and individuals.
    - Revision of the discovered injury investigation process.
    - Improvements in the documentation of activities taken during the investigation process.

Quality Assurance

- There was progress in the development of many aspects of a comprehensive QA program even though there was again change in the management of the QA department at MSSLC.
- The QA director should revise facility policies, based upon the new state QA policy. Also, given that the statewide policy was in development for more than a year, edits may already be needed.
- The QA director had made real progress towards the creation of a list of all of the data collected at the facility. This was newly created, so it was not surprising that much more work needed to be done.
- The QA Plan needed to be fully developed. It should consist of a number of components: a narrative description of how QA is conducted at MSSLC, and the QA matrix. The QA matrix was initiated, though it hadn't changed much since the last review.
- The monitoring team reviewed a number of tools completed by QA staff. There was a need for improvement in inter observer agreement, especially regarding the correct definition of each items, and an assurance that the QA staff obtained inter observer agreement with the QA director.

- A QA report did not yet exist at MSSLC. Only four sets of data were presented to the monitoring team.
- A series of QA-related meetings that were initiated by the interim facility director at the time of the last onsite review were continued by the newly appointed facility director: PIT, PET, and QAQI Council. Expectations for content and participation should be evaluated by the facility director.
- MSSLC made good progress in managing corrective actions. There were seven CAPs.

Integrated Protections, Services, Treatment, and Support

- DADS was thoroughly revising the ISP process and hired a set of consultants to help the SSLCs move forward in ISP development. MSSLC had not yet received technical assistance from the consultants and, therefore, had not begun implementation of the new ISP process.
- Three of the four annual IDT meetings scheduled during the review week were observed by the monitoring team. QDDPs were attempting to ensure that all necessary information was covered during the IDT meeting. Although there was good discussion in many areas, teams were not adequately addressing guardianship and consent, community integration, or placement options.
- There was little progress being made on developing plans that would lead to a more meaningful day for individuals. IDTs were still building plans around programming that was available at the facility rather than looking at what each individual may need or want. It appeared that an inordinate amount of time was spent meeting to address refusals to comply with treatment plans. Developing programming in response to preferences and individualized support needs would likely have a significant impact on the number of refusals to participate in treatment and programming.
- Assessments were needed to determine what services were meaningful to each individual served and what supports were needed to allow each individual to fully participate in those services.
- The facility had begun to use state developed audit tools to review both meeting facilitation and the ISP development process.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- The facility continued to make progress in this area. Several steps occurred, locally and at the state level, in an effort to integrate clinical services. State office developed a draft procedure Minimum and Integrated Clinical Services to address the requirements.
- It was clear that provision G was taken seriously and, since the last onsite review, more thought and work had been done. It was also apparent that much work remained and the medical director needed assistance, guidance, and support from the facility director because many actions needed to occur in areas and disciplines that were not under her purview.

- Throughout the week of the review, the monitoring team encountered several good examples of integrated clinical services. Areas where integration was needed, but failed to be evident, were also noted.
- The facility's activities related to section H focused entirely on the medical department. Almost every item related to the medical or psychiatric departments. More could have been and should have been accomplished over the past six months. There were, however, some positive findings. Routine assessments, such as annual medical assessments were being completed in a timely manner, and some clinical protocols had been implemented.

At-Risk Individuals

- MSSLC had taken some positive steps in this area, such as:
  - All individuals at MSSLC had been assessed using the statewide risk assessment.
  - Enhanced guidelines were developed by the psychology department to more accurately rate behavioral risks.
  - Training was provided to IDTs on all residential units regarding the appropriate way to complete the new risk rating and action plan forms.
  - Twelve individuals had been referred to the PNMT.
- While progress had been made by ensuring all individuals had been assessed and action plans were in place to address risks, teams were still not accurately identifying risk factors.
- Staff were not adequately trained on monitoring risk indicators and providing necessary supports. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual.
- The facility was still waiting on consultation and training on the new ISP and risk identification process from the state office. This training should move teams further towards integrating the risk process into the ISP development process.

Psychiatric Care and Services

- A lead psychiatrist was designated since the last visit. The lead psychiatrist, medical director, director of psychology, and the facility psychiatrists agreed upon the need for improved integration of clinical services. Most provision items in this section rely on collaboration with other disciplines.
- Psychiatry did not routinely attend meetings regarding behavioral support planning for individuals, and was not consistently involved in the development of the plans. Psychology could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, collaboration regarding case formulation). It was good to see that the nursing staff had designed the database to track the administration of the MOSES and DISCUS.

- Onsite neurology clinics had begun at MSSLC. The psychiatrist, however, was available to speak with the neurologist only at the end of the consultation. Unfortunately, this defeated the goal of the neurologist and the psychiatrist coordinating the use of medications.
- In most cases, the psychiatrist displayed competency in verbalizing the rationale for the prescription of medication, for the biological reasons 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.
- The evaluation, case formulation, diagnosis, and justification for treatment with medication remained insufficient. The adequate completion of psychiatric assessments, both quarterly and Appendix B comprehensive evaluations, were likely hampered by a lack of consistent and insufficient psychiatric resources.
- There was an overreliance on psychotropic medications, a paucity of non-pharmacologic interventions, and the use of multi-agent chemical restraints. The different departments must communicate with one another to allow for appropriate assessment and intervention to take place by the IDT.
- Facility-level data must include the overall information of how many individuals were prescribed psychotropics, and of these individuals, who received intra-class and/or interclass polypharmacy. The prescriber must justify the clinical hypothesis guiding said treatment.

Psychological Care and Services

- There was progress in several areas since the last review. This included an increase in the percentage of staff who wrote Positive Behavior Support Plan (PBSPs) that were enrolled in coursework toward attainment of board certification in applied behavior analysis, establishment of the collection of inter-observer agreement data (IOA) data, and improvements in the overall quality of functional assessments. In addition, there was continued development of evidence-based curriculums, goal directed services, and measurable treatment objectives for psychological therapies, other than PBSPs; and there were improvements in Positive Behavior Support Plans.
- More progress is required in ensuring that the service plans for all group and individual therapies include procedures for generalization of acquired skills. Further, the psychology department should expand the collection of IOA data for target behaviors, establish IOA target levels, and ensure achievement of those levels; develop a method to ensure that PBSPs are implemented with integrity; ensure that all functional assessments include a clear summary of the variables hypothesized to affect target behaviors; and ensure that all PBSPs are based on the hypothesized function of the target behavior, and specify clear, concise antecedent and consequent interventions.

Medical Care

- Some progress was found in the provision of medical services, primarily in the actions of the medical staff. During observations of IDT meetings, the Medical Review Committee meeting, and numerous other interactions, it was evident that most medical providers supported individuals in a manner that afforded the individuals an opportunity to have the best health possible. The facility should be encouraged by this finding. This was further supported by the detail of the discussions, the approach to the problems, and the documentation contained in the records.
- On the other hand, several records indicated that preventive services, such as colonoscopies were not provided. Overall, the facility will need to ensure that it is appropriately providing the necessary cancer screenings and has the IT framework to accurately track the required data elements.
- In addition, there was no facility policy developed for the state issued preventive care policy, and the preventive care flowsheet had not been implemented. There had been no quality initiatives undertaken at the facility level. The mortality system was rather dysfunctional and members of the Clinical Death Review Committee could not demonstrate implementation of their very own recommendations.
- Data integrity was problematic. There were marked discrepancies noted in the numbers for this review in comparison to the September 2011 review for several of the preventive care listings.
- Mammogram and colonoscopy data were listed as completed when that was not the case. The monitoring team noted several instances of grossly inaccurate data regarding several areas, including osteoporosis care and seizure outcome data.

Nursing Care

- MSSLC was making progress toward meeting many of the provisions of section M. The CNE reported that since the prior monitoring review, the Nursing Department had many accomplishments and improvements in all areas. He was correct.
- There was 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.
- 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.
- Many of the system improvements and processes, however, were initiated and developed at the top of the Nursing Department's organizational chart. During the review of individual's records, it became clear to the monitoring team that in order for MSSLC to achieve substantial compliance with the provisions of section M, all

nurses, from LVN to CNE, must be present, available, and competent to do their job and implement the systems developed to help them succeed.

- For example, the review continued to find problems with nurses who failed to respond appropriately to ensure adequate follow-up for individuals who had suffered acute illnesses and injuries. In addition, there were nurses who failed to implement many of the assessment and reporting protocols for the majority of the individuals reviewed. These failures jeopardized the individuals' health and safety and placed them at risk of harm.
- Notwithstanding these problems and challenges, there were many good changes and tremendous potential for further accomplishments.

Pharmacy Services and Safe Medication Practices

- Each of the four compliance visits was marked by the leadership of a different pharmacy director. The newest director was hired in September 2011. The frequent change at the director level prevented the type of gains in momentum that were needed to move towards substantial compliance. Nonetheless, progress was noted.
- Many issues that were noted in the September 2011 report, however, had not been addressed or were addressed immediately prior to the review. Important practices related to procedures, such as the drug regimen reviews, were implemented, but the policies were not formally revised.
- The procedures for communicating with prescriber were clarified and documentation improved. It was noted that improvement was needed in pharmacists reviewing orders relative to the need for lab monitoring. A Clozaril protocol was developed and implemented and that was good to see.
- The drug regimen reviews presented many challenges, both in the content and in terms of physician review. The clinical pharmacist provided some good information, but additional work was needed.
- ADR reporting increased since the last visit, but reporting continued to be completed largely by the clinical pharmacist. DUEs were completed on a quarterly basis, but the vastness of each DUE reduced its clinical relevance for the facility.
- The facility continued to report medication variances including pharmacy and prescribing errors. There was a failure to ensure that all medications were reconciled.
- The Pharmacy and Therapeutics Committee functioned in a very limited capacity. There was no agenda. There was a lack of a robust discussion. This was unfortunate because this committee provided oversight and guidance for many processes including DUEs, medication variances, adverse drug reactions, QDRRs, medication formulary, and all other matters related to medication practices for the facility.

Physical and Nutritional Management

- There was a fully-constituted PNMT. A meeting observed during this review showed some improvement in the process. All team members participated in discussion. It was of serious concern, however, that the PNMT was taking three to four months to complete an assessment, and only two had been completed in the last six months. The assessment was voluminous and consisted predominately of extensive medical history information, rather than an actual assessment of the individuals' current status and issues. It was difficult to discern actions taken, completed, and assessed for their effectiveness.
- Continued experience with the PNMT process will likely result in further refinement. The PNMT waited on referrals to initiate assessment or review. This was not necessary - key clinical indicators and health risk status should drive identification of the need for PNMT involvement. The PNMT may want to consider initiating review of all individuals with aspiration pneumonia, and other key indicators including bacterial/non-classified pneumonia, repeated hospitalizations, choking incidents, or significant or consistent weight loss, for example.
- Mealtimes were observed in a number of homes. Overall, there appeared to be improvements related to implementation of the dining plans, particularly in Barnett and Martin 4 dining areas.
- Positioning continued to be an issue, though, in general, the wheelchairs looked better. Staff continued to need training related to understanding effective alignment and support as well as the elements of transfers. Staff did not understand the relationship of individual risks and triggers to their duties and responsibilities. Monitoring frequency was nearing excessive and, as such, could not possibly be properly reviewed and analyzed.

Physical and Occupational Therapy

- The level of staffing for OT and PT clinicians had remained relatively stable; all of the staff had extended their contracts. The OT and PT clinicians conducted their annual assessments. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment (e.g., wheelchairs), and to review other supports and services.
- Despite this, there was a continued concern for continuity. A great deal of on the job training had to occur for new staff and there needs to be a clear plan for orientation to ensure consistency of the information passed on to new therapists joining the facility.
- There was a sound assessment template, with guidelines for the comprehensive assessment, though none of the assessments reviewed were consistent with it, and none included an appropriate analysis of findings or an adequate addressing of health risk levels in the context of the clinical findings.
- There continued to be a small number of individuals participating in direct PT and OT, though some also had programs and activity plans outlining additional supports and interventions. The majority of these were merely to ensure that the clinician conducted a quarterly review of equipment in the PNMP.

Dental Services

- Progress was noted in the provision of dental services. The facility continued to provide basic dental services onsite, while more advanced services were provided at a local hospital. Sedation and general anesthesia were not used at MSSLC and there was no plan to do so.
- Oral hygiene ratings improved, but very few individuals had good oral hygiene. Most had fair hygiene and individuals with poor or fair hygiene were required to have monthly clinic visits. The facility did not have a structured home oral care program. All staff were trained on the provision of oral care during pre-service training, but the dental clinic staff was not involved in the training.
- A few individuals received suction toothbrushing. That program was under the purview of the habilitation department. More individuals needed to be identified for this treatment.
- Annual assessments were completed with some minimal deficiencies noted. The facility opted to implement more stringent guidelines as a measure of remediation. Documentation improved due to the use of electronic charting, but the department will need to revaluate the format. Nonetheless, this was a great improvement because the records were legible. IPN entries were in SOAP format with the exception of notes pertaining to emergency visits.
- The facility continued to struggle with failed appointments. Approximately 20% of appointments failed over the six months prior to the onsite review. Missed appointments occurred because of staffing issues, off campus trips, and other medical appointments. There continued to be issues with refusals.

Communication

- As always, the SLPs were responsible for communication and mealtime supports for all of the individuals. These dual roles made the current ratios quite high, reported as 200, 42, and 127 for three clinicians, respectively. There were no SLPAs at the time of this onsite review, though there were three vacancies.
- Progress with completion of comprehensive communication assessments per the Master Plan was unclear based on the documentation submitted. Timeliness of completion of assessments appeared to be improved with more assessments completed prior to the ISP, most at least two weeks before the meeting, though 25% were completed after the ISP. Having appropriate content in the sections that address AAC and analysis of findings will be key to achievement of compliance in section R.
- The clinicians continued to report difficulties with implementation of AAC related to maintenance and consistent use throughout the day. There were Communication Instructions that included use of an AAC or environmental control device for only five individuals. A number of systems were recommended in the communication assessments, but without ongoing and consistent support provided by speech clinicians. This should not be the sole responsibility of direct support and day program staff.

Habilitation, Training, Education, and Skill Acquisition Programs

- This provision looks at skill acquisition, engagement in activities, and staff training. The facility was awaiting the development and distribution of a new policy in this area.
- There were several improvements observed since the last review, including the training sheets for Specific Program Objectives (SPOs) were revised, an integrity tool was developed to assess if SPOs were implemented as written, and a new tracking methodology for training activities in the community had been developed. In addition, there was continued support for individuals' who were entitled to educational services and coordination with the local independent school district.
- Areas to improve upon included ensuring that the rationale for each SPO clearly stated how acquiring this skill was related to the individual's needs/preference, ensuring that all of the components necessary for learning new skills are included in each SPO, and expanding the methodology used to teach SPOs. In addition, the facility should track SPO integrity measures, identify target levels of integrity, and ensure the achievement of those levels.

Most Integrated Setting Practices

- MSSLC continued to make progress towards substantial compliance. The number of individuals placed was at an annual rate of almost 9%. Approximately 11% of the individuals at the facility were on the active referral list. 17 individuals had been placed in the community since the last onsite review. 21 individuals were referred for placement since the last review. The total number of individuals on the active referral list was 42. The admissions and placement department staff made some graphs, but these were not of the data recommended by the monitoring team and were not done in a way that showed any trending.
- Twelve CLDPs were reviewed by the monitoring team. IDT members continued to be very involved in the placement activities of individuals. The monitoring team was impressed with the active role IDT members took in discussions during the CLDP meetings. Further, MSSLC ensured that at least one professional staff from the IDT visited and saw the home and day program for each individual at some point prior to his or her move.
- MSSLC made further improvements in the way it conducted and managed assessments in preparation for each individual's CLDP meeting. Very little detail, however, was provided regarding provider training and collaboration between MSSLC clinicians and the community clinicians (e.g., psychologists, psychiatrists).
- One CLDP meeting was observed by the monitoring team. Overall, there was good discussion and good participation. The transition specialist should work on improving the inclusion of the direct care staff member in the discussion and on facilitating the meeting in a smoother manner.
- MSSLC made progress in identifying essential and nonessential (ENE) supports, however, much work still needs to be done. This should be a priority area given the importance of this activity and the continued need for improvement. A number of important supports and services, based on the individual's preferences, safety

needs, and personal development needs were not included, evidence to show the provider's implementation of the ENE support needed improvement, and skills for the individuals to learn were noticeably absent.
- Post move monitoring had improved at MSSLC, resulting in a rating of substantial compliance. Observation of a post move monitoring also demonstrated improvement since the last review.
- T4 discharge summaries were not adequately or thoroughly completed.

Consent
- Some positive steps that the facility had continued in regards to consent and guardianship issues included that the Community Relations Director maintained contact with community resources for guardians and advocates and the HRO reviewed requests for advocates or guardians submitted by the IDTs. The Human Rights Officer continued to work with families applying for guardianship. MSSLC had not yet developed a priority list of individuals needing an LAR, IDTs were not adequately addressing the need for a LAR or advocate.
- The Human Rights Committee continued to meet and review all restrictions of rights. At the HRC meeting relevant discussion occurred, but did not adequately address important aspects of restrictions, informed consent, and LAR involvement.
- The facility had a self-advocacy group comprised of individuals residing at the facility.

Recordkeeping Practices
- MSSLC demonstrated continued progress towards substantial compliance in some areas of this provision, however, there were some areas in which there was no progress. Lack of progress was a result, in part, of the discontinuation of some of the previous department activities, such as graphing and trending of data.
- Overall, the active records were organized and well maintained. The record clerks did a good job of managing the active records. There continued to be a need for further improvement in all current documents being in the record (i.e., what MSSLC called delinquent documentation), legibility of entries, and proper signatures, as required by Appendix D.
- MSSLC made good progress in the use of the individual notebooks. This was due, in part, to the creation of work groups to address their use, policies and procedures, staff training, and regular monitoring. Overall, the general consensus was that the individual notebooks were being used and were helping staff to do their jobs.
- Master records were in place for every individual. Many needed to be organized according to a standard table of contents. There was still no satisfactory resolution as to what to do when items could not be located.
- The URC monthly audits were conducted as frequently as required, in a consistent manner, and on the proper forms. A number of improvements occurred since the last review. There was, however, no follow-up activity after the audit results were sent out by the recordkeeping staff.
- The URCs should create a set of graphs (described in V3); these graphs should be included in the QA program.

- The DRC and the URCs recently received the list of actions and topics that were now to comprise V4.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of MSSLC. The monitoring team hopes that the comments throughout this report are useful to the facility as it works towards meeting the many requirements of the Settlement Agreement. The monitoring team looks 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 DADS Policy: Use of Restraints 001 o Restraint Documentation Guidelines for SSLCs dated November 2008 o MSSLC Restraint Monitor Guidelines 2/29/12 o MSSLC Restraint Monitor Curriculum o MSSLC Crisis Intervention Guidelines Off Campus o Section C Compliance Data 10/1/11- 2/29/12 o Restraint Debriefing Log o Special Restraint Review Tracking Log o MSSLC FY12 Trend Analysis Report o MSSLC Self-Assessment o MSSLC Provision Action Information Log o MSSLC Section C Presentation Book o Performance Improvement Team Meeting Minutes 3/28/12 o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities o PMAB Training Curriculum 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 Nurse Check Longer than 30 Minutes From Start of Restraint Log o MSSLC "Do Not Restrain" list o List of individuals with desensitization plans (1) o Dental desensitization plans for #372 o Restraint Reduction Committee meeting minutes for past six months o List of all individuals who had a Safety Plan for Crisis Intervention o Training transcripts for 24 MSSLC employees o Documentation for medical restraints • Individual #518 (x2), Individual #438 (x2), Individual #151 (x3), Individual #377, Individual #143, and Individual #196 o ISPs, PBSPs, Safety Plans (when applicable), and ISPAs for: • Individual #519, Individual #466, Individual #29, Individual #436, Individual #518, Individual #293, Individual #196, Individual #143, Individual #377, Individual #438, Individual #491, Individual #126, Individual #151, Individual #56, Individual #51, and Individual #589.

- Individual #367, Individual #491, Individual #519, and Individual #65

o A sample of restraint documentation for behavioral intervention including:

Individual	Date	Type
#519	10/22/11	Physical
#519	10/15/11	Physical
#519	10/4/11	Physical
#519	9/22/11	Physical
#519	9/16/11	Physical
#519	9/14/11	Physical
#519	9/7/11	Physical
#519	9/5/11 2:43 pm	Physical
#519	9/5/11 4:58 pm	Physical
#519	9/2/11	Physical
#491	1/12/12 4:32pm	Physical
#491	1/12/12 2:37 pm	Physical
#491	1/12/12 2:03 pm	Physical
#491	1/5/12 6:25 am	Chemical
#491	1/5/12 5:50 am	Physical
#491	1/4/12	Physical
#491	12/12/11	Physical
#491	12/11/12	Physical
#491	12/9/11 11:15 pm	Physical
#491	12/9/11 11:00 pm	Physical
#347	10/26/11 6:40 pm	Physical
#347	10/26/11 6:50 pm	Physical
#347	10/26/11 7:30 pm	Chemical
#543	9/19/11 5:34 pm	Physical

#543	9/19/11 5:40 pm	Physical
#543	9/19/11 7:10 pm	Chemical
#589	2/11/12	Chemical
#589	2/7/12	Chemical
#56	3/5/12	Chemical
#436	2/14/12	Physical
#51	2/9/12	Physical
#466	2/8/12	Physical
#420	1/11/12	Physical
#431	10/10/11	Physical
#392	8/25/11	Physical
#126	2/15/12	Mechanical
#126	2/14/12	Mechanical
#126	2/10/12	Mechanical

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs
- Pat Samuels, Incident Management Coordinator
- Charlotte Kimmel, PhD, Director of Psychology
- Valerie McGuire, QDDP Coordinator
- Terri Moon, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 3/27/12 and 3/29/12
- Human Rights Committee Meeting 3/27/12
- Shamrock PIT Meeting 3/28/12
- Restraint Reduction Committee Meeting 3/28/12

Facility Self-Assessment:

MSSLC submitted its self-assessment. It was updated on 3/15/12. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement.

For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment

	activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using the tools developed by the state office to measure compliance with the Settlement Agreement. The self-assessment indicated that the findings from the facility's monthly audit process were used to self-assess compliance. The facility self-assessment commented on the overall compliance rating for each provision item, based on the sample of restraints audited. It did not describe criteria used to evaluate compliance for each item, how the sample was chosen, or details on specific findings. For example, for item C4, activities engaged in included: Review of Individual Support Plan Addendums for individuals who required medical restraints for routine medical or dental care. The results of the self-assessment noted: the interdisciplinary team has not consistently met to discuss these restraints and make recommendations. The self-assessment did not describe the sample size, how the sample was selected, what constituted compliance, or a compliance percentage for this particular activity. The facility was moving in the right direction with the new self-assessment process. It will be important to look at the self-assessment activities in more detail and determine if the audit process is an effective way to assess compliance. Facility compliance self-ratings were not in agreement with some of the compliance ratings found by the monitoring team. The facility assigned a rating of substantial compliance to provisions C1, C2, C3,and C6. The monitoring team agreed with one of these (C3) and also found rated C8 as being in substantial compliance even though the facility self-rated C8 as being in noncompliance..
	Summary of Monitor's Assessment: Based on information provided by the facility, there were 226 restraints used for crisis intervention between 9/1/11 and 2/29/12. • This was a 31% decrease from the 327 restraints that occurred in the previous six month period and a 53% decrease from the 483 restraint incidents during the same six month period of the previous year. • There were 214 physical restraints and 12 chemical restraints. From 8/25/11 through 2/10/12, the facility reported 20 incidents of restraint used for medical and/or dental treatment. • There were 20 incidents, including chemical, mechanical (mittens), and personal hold. • 11 individuals were the subject of medical restraints, There was a significant decrease in medical restraints from the 58 restraints reported during the last monitoring team visit.

	During observation at the facility, it was found that some mechanical restraints being used to address self-injurious behavior were classified as medical restraints by the facility and, therefore, were not routinely reviewed by IDTs, or reported in terms of restraints at the facility. These included mittens and helmets. This needs to be corrected and there was a new statewide plan to do so. According to the facility self-assessment, action taken by the facility to address compliance with section C since the last monitoring visit included: • Psychology staff had completed the statewide section C monitoring tool monthly on a sample of five restraints. • All restraints were being reviewed in the daily clinical services meeting, daily unit meeting, and Incident Review Team meeting. • A spreadsheet was developed to track restraint reviews and resulting recommendations. • The Behavior Support Committee was using a checklist to review ISPAs for individuals with more than three restraints in any rolling 30-day period to determine if compliance was met with section C7 requirements. • The facility "Do Not Restrain" list was updated and distributed to all residences. • An action plan was developed to address deficiencies noted in the last monitoring team report. The facility had made progress in meeting compliance with requirements for documenting and reviewing restraint incidents. Although there had been a decrease in the number of restraint incidents, there still were a significant number of restraints implemented over the past six months. 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. The facility was in substantial compliance with two of the eight provisions of section C.

#	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	A sample, referred to as Sample #C.1, was selected for review of restrain usage. Sample #C.1 was a sample of 30 physical, five chemical, and three mechanical (mittens) restraints for 13 individuals. Three of the individuals in the sample had the greatest number of restraints. Ten others were randomly selected. The individuals in this sample were Individual #491, Individual #519, Individual #347, Individual #543, Individual #589, Individual #56, Individual #436, Individual #51, Individual #466, Individual #420, Individual #431, Individual 392, and Individual #126. • Individual #126 was wearing mittens daily to prevent self-injurious behaviors. • Individual #491 had the greatest number of physical restraints, accounting for 22 (10%) of the 226 restraints for crisis intervention between 9/1/11 and	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	2/29/12. Individual #519 had the second greatest number each with 10 (4%) of the restraints. <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 30 physical restraint records for individuals in Sample #C.1 involving seven individuals, 0 (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> 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. It was not evident from documentation reviewed that restraint was always used as a last resort measure or that the restraint method used was the least restrictive method of intervention Restraint records were reviewed for Sample #C.1 that included documentation for 38 restraints. The following are the results of this review: • In 38 of the 38 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • In 33 of 35 (94%) restraints, staff documented events leading to the behavior that resulted in restraints. The three restraints for Individual #126 were not contingent on his behavior and, therefore, were not used in this sample. • Some example where staff adequately described events leading to the behavior: o The restraint checklist for Individual #589 dated 2/11/12 noted he became upset because of an altercation with a peer. o The restraint checklist for Individual #436 dated 2/14/12 indicated that he was upset because he could not have some ice cream. • Some examples where events leading to restraint were not adequately documented included: o In the area for the description of events on the restraint checklist for Individual #347 on 10/26/11, staff documented "broke out the window in his bedroom, walked off the home and went to the gym and broke out window at the storage building…" There was no documentation of the events leading up to his destructive behavior. o On the restraint checklist for Individual #51 dated 2/9/12 the	

#	Provision	Assessment of Status	Compliance
		description of events leading to the behavior noted "grabbed staff and pulled on her and hitting her and would not stop after being asked." Staff did not document in what activity the individual was involved prior to the incident. • In 29 of 35 the records (83%), 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 were o A horizontal hold was implemented on Individual #392 on 8/25/11 without prior interventions attempted, according to documentation. o A restraint checklist for Individual #519 dated 10/22/11 indicated that a restraint was implemented when he continued to try to burn a peer with his cigarette. Staff documented that verbal prompts were attempted prior to the restraint being implemented. There was no indication that his peer was asked to leave the area in order to diffuse the situation. o The restraint checklist for Individual #519 dated 10/4/11 indicated that staff implemented a physical restraint after attempting verbal prompts only. o Restraint checklists for Individual #519 dated 10/4/11, 9/16/11, and 9/2/11 indicated that staff implemented a horizontal hold prior to attempting a less restrictive hold. His safety plan instructed staff to begin with a less restrictive hold first, then move to a horizontal restraint if necessary. • In 5 of 35 instances of restraint, a chemical restraint was administered for crisis intervention. In each case (100%), staff documented other interventions that were attempted, but unsuccessful prior to the administration of a chemical restraint. It was not clear that all restraints used were the least restrictive intervention necessary. It was difficult to determine whether appropriate interventions were 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. The facility had established a Performance Improvement Team that reviewed significant data collected by the facility. These data included useful information regarding restraint incidents, peer-to-peer aggression, engagement, and program attendance. The team reviewed and discussed data, but stopped short of engaging in an integrated discussion regarding how each area of data may impact another, such as how restraint data may be related to refusals to attend programming or to peer to peer aggression. A more in-depth review of this data may lead to changes in programming and placement that would have a significant impact on the reduction of behaviors leading to restraint.	

#	Provision	Assessment of Status	Compliance
		A number of meetings attended during the week of the monitoring team's visit were held to discuss how the facility could address refusals to attend programming. The outcome of most of these meetings was to develop plans to reinforce attendance by rewarding the individual for attendance or punishment for failure to attend. There was very little discussion regarding why individuals were refusing to attend programming or what type of programming might be more meaningful to individuals at the facility. It was not evident that restraints were not used in the absence of, or as an alternative to, appropriate programming and treatment. Observation in the residential and day settings indicated that little progress had been made on addressing environmental factors contributing to situations requiring crisis intervention. Based on observations in day and residential programs, engaging individuals in more individualized and meaningful programming of interest would likely reduce crisis situations leading to restraints. During the monitoring visit, the monitoring team raised some concerns over individuals who were wearing protective equipment (mittens and helmets). IDTs were not addressing alternate strategies to reduce the use of protective equipment. Although IDTs were reviewing medical restraints, there was no indication that plans to reduce the amount of time spent in restraint were addressed by the IDT. Examples noted during observation at the facility are below. The monitoring team was aware that new policy and procedures were being developed by state office to address this. • Mittens were being used for protective restraint for Individual #293 and Individual #151. Neither ISP addressed the possibility of reducing the amount of time restraints were used or included instructions for staff regarding removing or monitoring the restraint. • Individual #438 was wearing a helmet. According to staff, the helmet was being used to protect her from injury from falls. There was no reference to the helmet in her ISP or PNMT. Her record did not include documentation of discussion by her IDT regarding use of the helmet or instructions for monitoring its use. Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 38 restraints, 38 (100%) were documented as approved restraints techniques. <u>Dental/Medical Restraint</u> The facility provided a list of pretreatment sedation and medical restraints between 8/1/11 and 2/10/12: • 11 individuals were the subject of pretreatment sedation, physical, or mechanical restraints during medical appointments. This included:	

#	Provision	Assessment of Status	Compliance
		• Nine instances of pretreatment sedation, and • Two personal arm holds for labwork. • Four individuals were the subject of mechanical restraint (mittens) to prevent self injury and promote healing including preventing removal of j-tube and g-tubes. Additionally, a list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that there was one medical desensitization plan in place. The facility was still in the beginning stage of developing desensitization plans and/or strategies to minimize the use of medical and dental restraints. The facility was not yet in compliance with provision C1. To do so: • Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint, and all interventions attempted prior to restraint. • When restraint is used, staff should follow PMAB guidelines for applying the least restrictive restraint type necessary. • The long term use of mechanical restraints should be reviewed periodically by the IDT and strategies should be developed to reduce the amount of time in restraint. • A schedule for monitoring the restraint and directions for assessing the criterion for release from restraint should be included in ISPs. • Desensitization programs should be developed for those individuals requiring the use of pretreatment sedation for routine medical appointments.	
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 for 13 individuals in Sample #C.1 were reviewed. Of these, six of the individuals had a Safety Plan for Crisis Intervention (SPCI). They were Individual #29, Individual #436, Individual #466, Individual #519, Individual #126, and Individual #491. Thirty-three individuals at the facility had an SPCI in place at the time of the review. Two of the six SPCIs reviewed (33%) did not give direction for the use of restraint and did not include release criteria (Individual #436, Individual #466). The Sample #C.1 restraint documentation for 30 physical restraints was reviewed to determine if the restraint was terminated as soon as the individual was no longer a danger to him/herself or others. • 27 of 30 (90%) restraints reviewed indicated that the individual was released immediately when no longer a danger.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• One restraint checklist indicated that Individual #491 was released after the maximum time allowed for restraint (30 minutes). • Two restraint checklists indicated that the individual was released because staff could not maintain the restraint correctly (Individual #491 dated 12/12/11, Individual #51 dated 2/9/12). SPCIs should include specific behavioral indicators to identify when release from restraint should be attempted based on knowledge about that individual. As noted in C1, the monitoring team found that some restraints may not have been the least restrictive alternative and, therefore, release could not have been as quick as possible. Having SPCIs in place that clearly direct staff in determining when an individual is an immediate risk for harm would prevent unnecessary restraints and provide guidance in determining what an individual should be released from restraint.	
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.	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 of 24 (100%) had current training in RES0105 Restraint Prevention and Rules. • 19 of the 24 (79%) employees with current training completed the RES0105 refresher training within 12 months of the previous training. • 24 of 24 (100%) had completed PMAB training within the past twelve months. • 21 of the 24 (88%) completed PMAB refresher training within 12 months of previous restraint training. MSSLC maintained substantial compliance with this provision item even though some of the trainings were not within 12 months. The monitoring team made this rating because most were within 12 months and the ones that were late occurred no more than 30 days late. MSSLC will need to ensure that all employees complete training annually as required by policy (i.e., within 12 months) in order to maintain substantial compliance.	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 38 restraint records (Sample #C.1), documentation in 35 (92%) indicated that restraint was used as a crisis intervention. Facility policy did not allow for the use of restraint for reasons other than crisis intervention or medical/dental procedures. The facility had not developed treatment strategies for all individuals who required the use of restraint for routine medical or dental care. According to a list provided to the monitoring team, a desensitization program had been developed for one individual who needed pretreatment sedation or restraint to have routine dental care completed. The plan included individualized strategies for the individual. The facility had created 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. The list specified what types of restraints should not be used. There was no evidence that anyone on the "Do Not Restrain" list had been the subject of restraint in the past six months. The facility did not adhere to restraint monitoring and review requirements for all protective mechanical restraints classified as medical restraint. The facility should ensure that these protective restraints are documented, monitored, and reviewed. For example, Individual #151 had mittens to prevent removing his tracheotomy tube. His ISP did not document that his IDT had discussed use of the mittens. There was no evidence that the team periodically reviewed this restraint or had attempted to develop strategies to allow for release from the restraint periods of his day. The team should meet with therapy and psychology staff to try to develop a plan to release his hand for activity, movement, or even massage for a period of time each day. Similarly, there were other individuals wearing mittens or helmets for a majority of their day. Teams should review all uses of mechanical restraints and document attempts at reducing the use of these restraints. IDTs should discuss the need for restraints during medical and dental procedures, and develop individual specific strategies to try to reduce or eliminate the need for restraint. The facility was not in compliance with this provision.	Noncompliance
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	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 38 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows:	Noncompliance

#	Provision	Assessment of Status	Compliance
	assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	• In 35 out of 38 incidents of restraint (92%), there was assessment by a restraint monitor. The exceptions were the three mechanical restraints for Individual #126. • In the 35 instances of restraint where there was a face-to-face assessment form completed, the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint in 34 (97%) instances. o The restraint monitor arrived 18 minutes from the start of the restraint for an incident involving Individual #491 dated 1/12/12 at 4:32pm. Based on a review of 35 physical and chemical restraints used for crisis intervention 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 27 (77%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #491 dated 1/12/12 (x2), 1/5/12 (x2), 1/4/12, and 12/12/11; o Individual #392 dated 8/25/11; and o Individual #466 dated 2/8/12. The facility had begun to track restraints for compliance with the requirement that a licensed health care professional conduct monitoring of restraints. A log submitted by the facility indicated that there had been 87 instances of late monitoring by the nurse between 8/16/11 and 3/26/12. The Restraint Reduction Committee was addressing this trend. A sample of restraints used for medical pretreatment sedation was reviewed for compliance with monitoring requirements. Two of 10 (20%) documented monitoring by a licensed health care professional at least every 30 minutes from the initiation of the restraint. The exceptions were: • The use of mittens for Individual #438 dated 1/1/12 and 2/1/12, Individual #518 dated 2/1/12 and 2/10/12, Individual #293 dated 2/1/12, and Individual #151 dated 1/1/12 and 2/1/12 • Pretreatment sedation for Individual #143 dated 1/24/12. The facility remained out of compliance with this provision. Monitoring by a nurse should be conducted and documented as required by state policy.	

#	Provision	Assessment of Status	Compliance
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. 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 35 (92%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. The three exceptions were the restraint checklist for Individual #126. His restraints were not contingent on behavior. • Thirty-three (87%) indicated what events were occurring that might have led to the behavior (see C1). • 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%) of 38 observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In 30 (100%) of 30 physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 30 (100%) of 30 physical restraints, 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. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. The longest restraint in the sample was 30 minutes in duration. In a sample of 38 records (Sample #C.1), restraint debriefing forms had been completed for 35 (92%). The exceptions were the three mechanical restraints for Individual #126. A sample of 10 restraint checklists for individuals receiving medical restraint was reviewed to ensure one-to-one supervision was provided. One-to-one supervision was documented in all 10 (100%). As noted in C5, only 20% of the medical restraints in the sample documented adequate monitoring by a healthcare professional. The facility was not in substantial compliance with this provision. Medical restraints	Noncompliance

#	Provision	Assessment of Status	Compliance
		should be monitored by a healthcare professional as required by the facility policy. The facility, however, had made significant progress in meeting compliance with this provision item C6.	
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 11 individuals were placed in emergency restraint more than three times in a rolling 30-day period. This represented a decrease from the last review when 17 individuals were placed in restraint more than three times in a rolling 30-day period. Four of the 11 individuals (36%) were reviewed to determine if the requirements of the Settlement Agreement were met (i.e., Individual #367, Individual #491, Individual #519, and Individual #65). Positive Behavior Support Plans (PBSPs), safety plans, and individual support plan addendums (ISPAs) following more than three restraints in a rolling 30-day period were requested for all four individuals. The results of this review are discussed below with regard to Sections C7a through C7g. Only two (i.e., Individual #491 and Individual #367) of the four ISPAs reviewed (50%) appeared to be in response to more than three restraints in a 30-day period. It was encouraging that one (i.e., Individual #491) of two ISPAs following more than three restraints in a 30-day period was organized so as to ensure that each of the issues below were discussed and documented (i.e., C7a-C7g). In order to achieve substantial compliance with C7, each individual's ISPA meeting minutes needs to reflect a discussion of each of the issues presented below, and a plan to address factors that are hypothesized to affect the use of restraints. Additionally, MSSLC needs to document that each individual's PBSP has been implemented with integrity, that specific procedures for training replacement behaviors for behaviors that provoke restraint has been developed (when possible and practical), and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent). Only one (Individual #491) of the four ISPA minutes reviewed (25%) reflected a discussion of adaptive skills, or biological, medical, or psychosocial factors affecting the behaviors provoking restraints. Individual #491's ISPA indicated that these variables were considered, but the treatment team concluded that no adaptive skills, biological, medical, or psychosocial factors were hypothesized to contribute to Individual #491's dangerous behaviors that provoked restraint.	Noncompliance

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		In order to achieve substantial compliance with this provision item, the minutes from each individual's ISPA meetings following more than three restraints in a rolling 30-day period should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	
	(b) review possibly contributing environmental conditions;	Two (Individual #491 and Individual #367) of the four ISPAs reviewed (50%) reflected a discussion of possible contributing environmental factors to the behavior or behaviors provoking restraint. Individual #491's ISPA documented a discussion of how the lack of male staff in the home may result in an increase in the behaviors provoking restraint. The ISPA, however, did not reflect a discussion of how these environmental conditions hypothesized to contribute to her restraints would be addressed. Individual #367's ISPA reflected a discussion of how delay of meals often appeared to trigger dangerous behaviors that result in restraints. Additionally, Individual #367's ISPA documented that, in order to decrease the likelihood of dangerous behavior following a delay in meals, the team decided that snacks would be provided if a meal was delayed 15 minutes or more. All ISPA minutes of meetings in response to more than three restraints in a thirty-day period 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 behaviors that provoke restraint. None of the ISPA minutes reviewed (0%) reflected a discussion of potential environmental antecedents. Examples of possible environmental antecedents include things, such as the cancelling of an outing or being told to wait. In order to achieve compliance with this provision item, ISPA minutes need to reflect a discussion of the effects of these types of variables on the individual's restraint, and (if they are hypothesized to affect restraints) a discussion of an action plan to eliminate these antecedents or reduce their effects on the dangerous behavior that provokes restraint.	Noncompliance
	(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. None of the ISPA's reviewed (0%) included a discussion of a variable or variables maintaining the dangerous behavior that provoked restraint. An example of what could be included here is an individual whose ISPA reflected a conversation that their physical aggression that often leads to restraint could be	Noncompliance

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		maintained by escape or avoidance of undesirable activities. The intervention, or action based on that hypothesis, could be to establish and reinforce a functional replacement behavior (see K9), such as communicating that the individual wants a break.	
	(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 four of the individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Four (100%) were based on the individual's strengths, • Four (100%) specified the objectively defined behavior to be treated that led to the use of the restraint, • Three (75%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiated the use of the restraint (Individual #65 is the exception), and • Four (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint One of the four PBSPs (25%) to weaken or reduce the behaviors that provoked restraint, however, was determined to be inadequate (i.e., Individual #65) because it did not contain clear, precise interventions based on a functional assessment (see K9). This represented an improvement from the last review when 38% of the PBSPs were determined to be inadequate. The four safety plans of the individuals in the sample were reviewed. The following represents the results: • In all four of the Safety Plans reviewed (100%), the type of restraint authorized was delineated, • In three (75%) of the safety plans reviewed (exception was Individual #519's safety plan), the maximum duration of restraint authorized was specified, • In all (100%), the designated approved restraint situation was specified, and • In all (100%), the criteria for terminating the use of the restraint was specified.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	For none of the individuals reviewed (0%) were integrity data available demonstrating that the PBSP was implemented with a high level of treatment integrity (see K4 and K11 for a more detailed discussion of treatment integrity at the facility).	Noncompliance

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	(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.	Thirty-five (100%) restraints in the sample indicated review of the restraint within three days of restraint incident. A sample of Face-to-Face Debriefing and Review Forms related to 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 IMT and all 35 restraints in the sample were signed by both the Unit Director and IMT. All restraints for crisis intervention were being reviewed in the daily clinical services meeting, daily unit meeting, and Incident Review Team meeting. Restraint incidents were also referred to the IDT for follow-up. There was good discussion, including relevant comments regarding changes to treatments and strategies. The facility was now maintaining a log of all recommendations made for corrective action during restraint debriefings. Some restraints were reviewed by a psychologist at the request of Dr. Kimmel when warranted. Any additional recommendations were included on the Special Restraint Review Tracking Log. When restraint techniques were in question, the video of the restraint was reviewed with staff. Significant improvement had been made in the quality of restraint reviews. Additionally, the facility had a review form to be completed by the psychiatrist for chemical restraints. This form was completed on three (50%) of six chemical restraints in the sample. Exceptions were: • Individual #491 on 12/12/11 • Individual #543 on 9/19/11, and • Individual #347 on 10/26 /11. The facility had an adequate system in place for the administrative review of restraint incidents and an adequate system for the review and modification of treatments and strategies for review of restraints as per this provision item. Note, however, that the reviews of individuals who were restrained more than three times in any rolling 30-day period did not yet meet the requirements of the Settlement Agreement (see C7).	Substantial Compliance

Recommendations:

1. The long term use of mechanical restraints should be reviewed periodically by the IST and strategies should be developed to reduce the amount of time in restraint. A schedule for monitoring the restraint and directions for the frequency of release from restraint should be included in ISPs (C1, C2, C4).

2. When restraint is used, staff should follow PMAB guidelines for applying the least restrictive restraint type necessary (C1).

3. 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).

4. The facility should ensure that protective restraints are documented, monitored, and reviewed. When applicable, plans to reduce the behavior resulting in restraint should be addressed by the IDT (C1, C4).

5. 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).

6. SPCIs should specify specific behavioral indicators to identify when release from restraint should be attempted (C2, C4).

7. IDTs should discuss the need for restraints during medical and dental procedures and strategies should be developed to try to reduce or eliminate the need for restraint (C2, C4).

8. Monitoring by a nurse should be conducted and documented as required by state policy (C5).

9. 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 MSSLC Section D Self-Assessment 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 MH&MR Investigations Handbook Commencement Policy Effective 8/1/11 o Information used to educate individuals and their LAR on identifying and reporting unusual incidents o Incident Management Committee meeting minutes for each Monday of the past six months o Human Rights Committee meeting minutes for the past six months o Three most recent five-day status reports o Training transcripts for 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 (38) o List of staff who failed to report abuse, neglect, or exploitation (0) o List of reporters that are known to be an individual or LAR (0) 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 EPSSLC o Abuse/Neglect/Exploitation Trend Reports FY12 o Injury Trend Reports FY12 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 ISPs for Individual #126, Individual #143, Individual #377, Individual #589, Individual #56, Individual #293, Individual #238, Individual #183, Individual #590 and Individual #373. o Injury reports for three most recent incidents of peer-to-peer aggression incidents o ISP, BSP and ISPA 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 all injuries for the past six months o List of all A/N/E allegations since 9/1/11 including case disposition o List of all investigations completed by the facility since 9/1/11 o List of employees reassigned due to ANE allegations o Injury reports for the past three months for Individual #160, Individual #562, Individual #235,

Individual #221, Individual #101, Individual #300, Individual #135, Individual #295, Individual #233, Individual #473, Individual #456, Individual #386, Individual #266, and Individual #96

- Documentation from the following completed investigations including follow-up:

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#40297262	Emotional/Verbal Abuse (2) Neglect Physical Abuse	Unconfirmed (2) Unconfirmed Unconfirmed	10/3/11 10:21 pm	10/5/11 11:50 am	10/20/11
#40298333	Physical Abuse (2)	Inconclusive Unfounded	10/4/11 4:39 pm	10/6/11 2:05 pm	10/13/11
#40303679	Neglect (2) Physical Abuse	Unconfirmed Confirmed Confirmed	10/8/11 10:59 pm	10/9/11 12:10 am	11/23/11
#40814756	Emotional/Verbal Neglect Physical Abuse	Unconfirmed Unconfirmed Other	12/8/11 3:45 pm	12/9/11 3:35 pm	12/28/11
#40987026	Physical Abuse	Unconfirmed	12/30/11 5:12 pm	12/31/11 10:35 am	1/9/12
#40685116	Neglect (2) Physical Abuse	Confirmed (2) Confirmed	11/26/11 7:13 pm	11/27/11 1:00 pm	12/17/11
#41122499	Neglect Physical Abuse (2)	Unconfirmed Unconfirmed (2)	1/18/12 3:31 pm	1/19/12 7:43 am	1/28/12
#41196384	Neglect (2)	Confirmed (2)	1/28/12 11:59 pm	1/31/12 3:24 pm	2/7/12
#41264198	Neglect	Confirmed	2/7/12 7:43 pm	2/9/12 8:03 am	2/16/12
#41306553	Neglect	Unconfirmed	2/13/12 3:57 pm	2/16/12 6:37 am	3/4/12
#41315012	Physical Abuse	Unconfirmed	2/19/12 10:39 pm	2/21/12 11:00 am	2/27/12
#41363133	Emotional/Verbal Abuse Neglect	Unfounded Unfounded	2/24/12 12:38 pm	2/25/12 6:56 pm	3/5/12
#41391258	Emotional/Verbal Abuse	Unconfirmed	2/27/12 6:58 pm	3/1/12 5:00 pm	3/8/12
#41419138	Physical Abuse	Unfounded	3/1/12 3:51 pm	3/4/12 8:00 am	3/11/12
#41429032	Physical Abuse	Unconfirmed	3/2/12 12:35 pm	3/3/12 4:10 pm	3/8/12

Sample D.2	Type of Incident	DFPS Disposition	Date of DFPS Referral	DFPS Completed Investigation	Facility Completed Investigation
#40628551	Neglect	Administrative Referral	11/18/11	11/23/11	12/9/11
#41330153	Physical Abuse	Administrative Referral	2/21/12	2/27/11	3/13/12
#41419138	Physical Abuse	Administrative Referral	3/1/12	3/11/12	3/14/12
#4145287	Emotional/Verbal Abuse	Administrative Referral	3/5/12	3/7/12	3/12/12

Sample D.3	Type of Incident	Date/Time of Incident Reported	Director Notification		
#40	Encounter with Law Enforcement	9/12/11 12:30 pm	9/12/11 1:18 pm		
#108	Serious Injury	10/2/11 11:00 pm	10/2/11 11:05 pm		
#356	Encounter with Law Enforcement	11/30/11 11:55 am	11/30/11 2:02 pm		
#479	Serious Injury	1/11/12 11:05 am	1/11/12 11:50 am		
#539	Serious Injury	1/30/12 4:48 pm	1/30/12 4:55 pm		
#597	Serious Injury	2/21/12 4:20 pm	2/21/12 4:35 pm		

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs
- Pat Samuels, Incident Management Coordinator
- Charlotte Kimmel, PhD, Director of Psychology
- Valerie McGuire, QDDP Coordinator
- Terri Moon, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 3/27/12 and 3/29/12
- Human Rights Committee Meeting 3/27/12

	o Shamrock PIT Meeting 3/28/12
	Facility Self-Assessment: MSSLC submitted its self-assessment. It was updated on 3/15/12. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using the tools developed by the state office to measure compliance with the Settlement Agreement. The self-assessment indicated that the findings from the facility's monthly audit process were used to self-assess compliance. The facility self-assessment commented on the overall compliance rating for each provision item, based on the section D audit. The self-assessment described criteria used to evaluate compliance for each item, and commented on specific findings. The facility is moving in the right direction with the new self-assessment process. It will be important to look at the self-assessment activities in more detail and determine if the audit process is an effective way to assess compliance. The facility assigned a rating of substantial compliance to provisions in section D. The monitoring team did find substantial compliance in 19 of 24 provisions. Although significant progress had been made, the monitoring team rated provisions D2a, D3g, and D3i out of compliance.
	Summary of Monitor's Assessment: According to information provided to the monitoring team, investigations of 1222 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility in the six months prior to the monitor's visit. The incident management department continued to struggle with the large number of spurious allegations submitted by individuals at the facility. Of the 1222 allegations reported to DFPS, 366 of these (30%) were deemed to be spurious allegations by DFPS investigators. There were a significant number of confirmed allegations, however, including 22 confirmed cases of physical abuse, one confirmed case of sexual abuse, three confirmed cases of emotional/verbal abuse, and six confirmed cases of neglect. A list of all serious incidents investigated by the facility during the previous six months was requested by the monitoring team. The facility did not provide that information. In order to address trends in incidents, the facility will need to develop a system to track and trend all incidents.

	There were a total of 1386 injuries reported between 8/1/11 and 2/27/12. These 1386 injuries included 36 serious injuries resulting in fractures or sutures. It was not evident that the facility was adequately addressing the high number of injuries documented at the facility with preventative actions. Documentation indicated that a large number of injuries were resulting from behavioral issues including peer-to-peer aggression. The facility needs to aggressively address tends in injuries and implement protections to reduce the number of incidents and injuries. The facility had taken steps to address concerns related to incident management at the facility. Some positive steps taken to address the provision items of section D included: • Creating a database to maintain and track disciplinary action related to allegations of abuse, neglect, and exploitation. • Revision of the employee abuse, neglect, and exploitation competency test. • The facility began using the new state office Avatar system for documenting investigations. • Inservice for all QDDPs on providing information and educating LARs, family members, and individuals on identifying and reporting unusual incidents, including abuse and neglect. • Revising the discovered injury investigation process. • The DADS Section D Monitoring Tool was implemented. • Improvements were made in the documentation of activities taken during the investigation process. As noted below in the findings for section D, it was not apparent that some of these steps had adequately addressed concerns noted in previous monitoring reports. The facility needs to focus next on: • Creating a database that accurately identifies all unusual incidents. • Ensuring investigation files include documentation of follow-up to all recommendations and concerns. • Ensuring IDTs are adequately addressing all incidents and putting necessary protections in place. • Ensuring that the facility audit system accurately identifies areas of needed improvement.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures 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 all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee.	Substantial Compliance

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		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. • 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. o 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. o Signed forms were provided for all employees hired within the past two months. The facility provided a copy of the signed acknowledgement for 38 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. Documentation of disciplinary action was reviewed for four cases in which DFPS substantiated an allegation of abuse or neglect and the AP was known. In all cases (100%), disciplinary action was documented, though not necessarily in the investigation file. • In DFPS case #40303679, one allegation of neglect and one allegation of physical abuse were confirmed on two employees. One employee received a 10 day suspension and the other was terminated. • In DFPS case #40685116, the AP was terminated on 2/9/12 after DFPS returned a confirmed neglect allegation on 12/17/11. • In DFPS case #41196384, the investigation was completed on 2/7/12. The AP was terminated on 3/8/12 following two confirmed allegations of neglect. • In DFPS case #41264198, completed 2/16/12, an employee was terminated on 3/8/12 following a confirmed allegation of neglect. For cases where disciplinary action was warranted, it appeared that the facility was taking a position of "no tolerance" for abuse and neglect. The facility reported that no evidence had been found that an employee had failed to report abuse or neglect since the last monitoring visit. A review of incidents in sample D.1 indicated	

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		• In DFPS case #40303679, a DSP witnessed physical abuse, but did not report it. She was found negligent by DFPS and the facility suspended her for 10 days. The facility remained in substantial compliance with this provision.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	According to DADS Incident Management Policy 002.3, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. With regard to other serious incidents, the state policy addressing Incident Management required that all unusual incidents be reported to the facility director or designee within one hour of witnessing or learning of the incident. This included, but was not limited to: • Allegations of abuse, neglect, or exploitation, • Choking incidents • Death or life-threatening illness/injury • Encounter with law enforcement • Serious injury • Sexual incidents • Suicide threats • Theft by staff, and • Unauthorized departures. The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This 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 1222 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility since the last monitoring visit. From these 1222 allegations, there were: • 761 allegations of physical abuse; o 22 were confirmed, o 317 were unconfirmed,	Noncompliance

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		o 112 were referred back to the facility for further review o 238 were unfounded, o 9 were inconclusive, o 2 were merged into other cases, and o 61 were pending outcomes. • 76 allegations of sexual abuse; o 1 was confirmed, o 11 were unconfirmed, o 5 were referred back to the facility for further review, and o 59 were unfounded, • 192 allegations of verbal/emotional abuse, o 3 were confirmed, o 79 were unconfirmed, o 35 were referred back to the facility for further investigation, o 55 were unfounded, o 3 were inconclusive, and o 17 were pending outcome. • 191 allegations of neglect; and o 6 were confirmed, o 79 were unconfirmed, o 62 were referred back to the facility for review, o 14 were unfounded, o 1 was inconclusive, o 2 were merged into other cases, and o 17 were pending outcomes. From all investigations since 9/1/11 reported by the facility, 25 investigations were selected for review. The 25 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 not reportable to DFPS. Based on a review of the 15 investigative reports included in Sample #D.1: • Five incidents occurred at an unknown time. Ten of 10 reports in the sample (100%) indicated that DFPS was notified within one hour of the incident or discovery of the incident.	

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		• Fifteen of 15 (100%) indicated, the facility director or designee was notified within one hour by DFPS. • Thirteen of 13 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. • Thirteen of 15 (87%) indicated that the state office was notified as required. Cases that did not include documentation of state office notification were DFPS #40298333 and DFPS #41122499. In reviewing Sample D.3 (serious incidents), documentation indicated: • Four of six (67%) were reported immediately (within one hour) to the facility director/designee. o UIR #40 indicated that the facility was notified of an encounter with law enforcement by MISD before 8:50 am on 9/12/11. The facility director was not notified until 1:18 pm. o UIR #356 indicated that an encounter with law enforcement was reported on 11/30/11 at 11:55 am. The facility director was notified at 2:02 pm. • Documentation of state office notification was found in all six (100%) UIRs. o Only one case was reportable to DADS Regulatory. Notification was made as required. The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents in the sample. 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: • 15 out of 15 (1000%) investigation files in Sample #D.1. • 10 of 10 (100%) investigation files in Sample #D.2 and Sample #D.3. Fifty-nine serious injuries occurring since 9/1/11 were reviewed to determine if serious injuries were reported for investigation. • The facility did not keep a log of investigations of incidents not involving abuse, neglect, or exploitation, so it was not possible to ensure all injuries had been investigated. • Of the three serious injuries reviewed in Sample #D.3, two (67%) were reported to the facility director within one hour of determination of a serious injury. UIR #108 involved a serious injury that occurred on 9/30/11. It was not reported for investigation until 10/2/11. At that time, the facility director was notified. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. All employees signed an acknowledgement form	

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		annually. A sample of this form was reviewed for 38 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. Based on an interview of six staff responsible for the provision of supports to individuals, six (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation and other serious incidents. The facility was not in substantial compliance with the reporting requirements of this provision. The sample reviewed did not support that notifications were made in a timely manner in all cases.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	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 15 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. The monitoring team was provided with a log of employees who had been reassigned since 9/1/11. The log included the applicable investigation case number, the date of the incident and the date the employee was returned to work or in some cases discharged. In 15 out of 15 cases (100%) there was no evidence that the employee was returned to client contact prior to the completion of the investigation or when the employee posed no risk to individuals. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 15 investigation files in Sample D.1, 15 (100%) UIRs documented additional protections implemented following the incident. For example, • In DFPS case #40297262, the UIR indicated that a physical assessment was completed by a nurse, for both individuals involved in the incident. The AP was placed in a position of no contact with individuals. The standardized UIR form had recently been revised by the State Office. All investigations were completed using the new UIR format. Description of corrective actions taken was much more detailed on these reports. The facility was in substantial compliance with this provision.	Substantial Compliance

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	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 20 (100%) of 20 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. • 18 (90%) of the 20 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. Based on interviews with six direct support staff in various homes and day programs: • Six (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to 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 reviewed for 38 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. 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. A sample of 15 DFPS reports included an example where employees failed to report abuse. In DFPS #40303679, two employees were charged with neglect for failing to report the incident. The failure to report was addressed with disciplinary action. The facility was in substantial compliance with this item.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing	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	Substantial Compliance

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	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.	information on how to report suspected abuse and neglect. A sample of 10 ISPs developed after 9/1/11 was reviewed for compliance with this provision. The sample included ISPs for Individual #126, Individual #143, Individual #377, Individual #589, Individual #56, Individual #293, Individual #238, Individual #183, Individual #590 and Individual #373. • Eight (80%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. Exceptions were Individual #589 and Individual #126. In informal interviews with individuals during the review week, all individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. There were numerous examples in the sample of individuals reporting abuse or neglect directly to DFPS. The facility remained in substantial compliance with this item.	
	(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. 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. Campus Administrators monitored and reviewed postings in each living unit and day program and were instructed to report missing posters as necessary.	Substantial Compliance
	(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 15 allegation investigations completed by DFPS (Sample #D.1),	Substantial Compliance

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		DFPS notified law enforcement and OIG of the allegation in 13 (100%), as appropriate.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	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 occurred. The facility was asked for a list of staff who alleged that they had been retaliated against for in good faith had reported an allegation of abuse/neglect/exploitation. The facility reported zero cases where fear of retaliation was reported. Based on a review of investigation records (Sample #D.1), there were no concerns noted related to potential retaliation for reporting. The facility rated itself in substantial compliance with this item. The monitoring team agreed with that assessment.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	According to the facility self-assessment, the following measures had been implemented to address this provision. • Quarterly audits of non-serious injuries were conducted to identify trends and ensure that significant injuries were reported for investigation. • Audits of injuries were reviewed by the IMRT • Injuries were reviewed in daily unit meetings. Sample #D.3 included investigations completed on a sample of three serious injuries. All three investigations were thorough and completed using a standardized UIR. The monitoring team observed daily IMRT meetings held the week of the onsite review. All injuries were reviewed and discussed by the team. Serious injuries, suspicious injuries, and trends of injuries were investigated further and recommendations were made by the team for follow-up. 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. The review process included reviewing information gathered regarding the injury and making recommendations for preventative action or reporting the injury to DFPS when applicable. As noted in D2a, an additional sample of serious client injuries was reviewed for serious	Substantial Compliance

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		injuries occurring in the past six months to determine if injuries were reported for investigation. According to a list of all investigations completed by the facility, all serious injuries in the sample had been investigated. Based on observations and the sample of documentation reviewed, the facility's audit process was adequate for ensuring that injuries or trends of injuries were reported for investigation.	
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.	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 conducting investigations and working with people with developmental disabilities. Four 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 regarding individuals with developmental disabilities. MSSLC had nine employees designated to complete investigations. The training records for those designated to complete investigations were reviewed with the following results: • Nine (100%) facility investigators had completed CIT0100 Comprehensive Investigator Training or CSI 0100 Conducting Serious Incident Investigations. • Nine (100%) had completed UNU0100 Unusual Incidents within the past 12 months. • Nine (100%) had completed Root Cause Analysis according to training transcripts reviewed.	Substantial Compliance

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		• Nine (100%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. Trained investigators were completing all investigations at the facility. 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.	Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. There was no indication that facility staff had failed to cooperate with investigators in any of the cases. The facility IMC continued to meet quarterly with DFPS and OIG to discuss coordination of investigations between agencies. The facility was in substantial compliance.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS, the following was found: • Of the 15 investigations completed by DFPS (Sample #D.1), 13 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. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility was found to be in substantial compliance with this provision.	Substantial Compliance

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	(d) Provide for the safeguarding of evidence.	The MSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or 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.3): • There was no indication that evidence was not safeguarded during any of the investigations. For one investigation in the sample, a hairbrush appeared to line up with bruises found on the individual. Documentation indicated that the hairbrush was immediately secured as evidence. Video surveillance was in place throughout MSSLC, and investigators were regularly using video footage as part of their investigation. The facility remained in substantial compliance with this item.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	DFPS had implemented a new commencement policy effective 8/1/11. Mandates in the new policy were described in the MH & MR Investigations Handbook published on 10/1/11. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Investigations noted the date and time of initial contact with the alleged victim. o Contact occurred within 24 hours in 11 of 15 (73%) investigations. The four in which contact did not occur were DFPS cases #40297262, #40298333, #41196384, and #41264198. • Fifteen (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. For the four investigations in which initial contact was not made with the alleged victim, this included gathering other documentary evidence and making initial contact with the facility. • Eleven of 15 (73%) were completed within 10 calendar days of the incident. o Extensions were filed in all cases that were not completed within 10 calendar days. o Investigation #40303679 was the lengthiest investigation in the sample. It was completed on the 44th day. Documentation included five extension requests. Proper procedures were followed and all extensions seemed warranted. o It was not evident in all cases when extensions were filed that extraordinary circumstances were a factor. For example, ▪ In DFPS case #40297262, the case was extended due to the unavailability of the AP for interview. The first attempt to	Noncompliance

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		contact the AP was eight days following receipt of the report. Immediate contact with the AP to schedule an interview would have prevented the delay. ▪ In DFPS case #40814756, the first attempt documented to interview the reporter by phone was on the eighth day of the investigation. The first attempt to interview the AP in the case was documented as occurring on the 12th day of the investigation. o This was an overall trend of investigations being completed in a timelier manner compared with the 45% found during the last onsite review. • All 15 (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 twelve of the 19 DFPS investigations reviewed (63%) in sample #D.1 and #D.2, concerns or recommendations for corrective action were included. Four of those cases resulted in administrative referrals. Concerns were appropriate based on evidence gathered during the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3 : • Only one (17%) of the UIRs reviewed indicated when the investigation commenced. UIR #479 included the date and time witness statements were taken. o UIR #40 did not indicate when investigative activities occurred. o UIR #108 indicated that the investigator was notified of the incident on 10/2/11, but did not commence the investigation until 10/9/11. o UIR #356, UIR #539, and UIR #597 did not clearly indicate when the investigation commenced. • Six of six (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Three of six (50%) investigations included recommendations for corrective action. 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 clearly reflects the time and date of investigative activities. Efforts should continue to complete investigations within 10 days unless extraordinary circumstances exist. This was a repeat finding from the last monitoring visit.	

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	(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.	DADS 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.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 15 (100%), each serious incident or allegations of wrongdoing;
		o In 15 (100%), the name(s) of all witnesses;
		o In 15 (100%), the name(s) of all alleged victims and perpetrators (when known);
		o In 15 (100%), the names of all persons interviewed during the investigation;
		o In 15 (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 15 (100%), all documents reviewed during the investigation;
		o In 15 (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 In 15 (100%), the investigator's findings; and
		o In 15 (100%), the investigator's reasons for his/her conclusions.
		
		<u>Facility Investigations</u>
		The following summarizes the results of the review of seven facility investigations included in sample #D.3
		• The report utilized a standardized format that set forth explicitly and separately, the following:
		o In six (100%), each serious incident or allegations of wrongdoing;
		o In six (100%), the name(s) of all witnesses;
		o In six (100%), the name(s) of all alleged victims and perpetrators when known;
		o In five of six (83%), the names of all persons interviewed during the investigation;
		▪ In UIR #40, there were no interviews conducted.
			Substantial Compliance

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		o In five (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 six (100%), all documents reviewed during the investigation; o In five (83%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. UIR #356 did not include a review of prior incidents. o In six (100%), the investigator's findings; and o In six (100%), the investigator's reasons for his/her conclusions. The facility was in substantial compliance with this item.	
	(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.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 a sample of 15 DFPS investigations included in Sample #D.1: • In 15 (100%) investigative files reviewed from Sample #D.1, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and director of facility. For UIRs completed for Samples #D.1, • Fifteen (100%) DFPS investigations were reviewed by both the facility director, and IMC following completion. o Eleven of 15 (73%) were reviewed by the facility director and Incident Management Coordinator within five days of receipt of the completed investigation. Exceptions included: ▪ DFPS #40297262 – reviewed 7 days after completion, ▪ DFPS #40303679 – reviewed 7 days after completion, ▪ DFPS #41315012 – reviewed 11 days after completion, ▪ DFPS #41363133 – reviewed 7 days after completion, • DFPS noted concerns or made recommendations in eight (53%) of the cases in sample #D.1. The facility maintained a log of follow-up action taken to address concerns and recommendations. Documentation of follow-up was not found in all investigation files making it difficult to track follow-up documentation. For	Noncompliance

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		example, o In DFPS #40685116, the review approval form listed a date of completion for each of the three DFPS concerns noted. A copy of the disciplinary action letter for the AP was included in the file to address one recommendation. Documentation of follow-up was not included for the other two recommendations. Follow-up to this case was not included on the follow-up tracking log submitted by the facility. o In DFPS #41419138, the DFPS investigator noted a concern regarding conflicting information in the individual's PBSP and PNMT. The investigation file did not include documentation of follow-up by the facility. The concern was not noted in the UIR or included on the facility follow-up tracking log. • Sample #D.2 included four investigations that were referred back to the facility for administrative review. All four appeared to be unfounded allegations. The facility did not recommend any further action in the cases. Two daily review meetings (DRM) were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily DRM meetings. These meetings were led by the Incident Management Coordinator. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> • In six of six (100%) UIRs from sample #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. • Three of six (50%) of the reviews by the IMC were completed within five days of the completion date. The exceptions were UIR #356, UIR #479, and UIR #597. • Two of the UIR included recommendation for follow-up. o UIR #108 was the investigation of a serious injury. The UIR included three recommendations for follow-up. A completion date was listed for each recommendation, but there was no documentation of what follow-up occurred. o UIR #539 did include documentation of follow-up by the IDT to address a serious injury. The facility needs to ensure that all investigations are reviewed in a timely manner to ensure swift follow-up action when indicated. Documentation of follow-up to recommendations should be included in the investigation file.	

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	(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 35 out of 35 (100%) unusual incidents in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form.	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.	Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations in a sample of 10 investigations. Four investigations in Sample D.1 included confirmed allegations of abuse or neglect. Documentation provided by the facility indicated that disciplinary action had been taken in all four cases. The facility had developed a log to track follow-up action taken in regards to recommendations included in investigations. In eight of 15 DFPS cases reviewed from Sample #D.1, DFPS documented additional concerns or recommendations. In three of those eight cases (38%), the facility investigation file did not include documentation that concerns or recommendations were addressed. Examples found where documentation of programmatic action was not adequate included: • In DFPS #41315012, a concern was noted regarding a rights issue. The issue was not addressed in the UIR and there was no indication that the facility addressed the concern. • In DFPS #41419138, the investigator noted a concern regarding conflicting information in the individual's PBSP and PNMP there was no documentation of follow-up to this concern. Recommendations for programmatic actions were made in two of six cases reviewed for facility investigations in Sample #D.3. Follow-up documentation was included in one of the two cases (50%) that included recommendations. The facility needs to ensure that appropriate follow-up action is completed and documented. The facility did not maintain substantial compliance with this item.	Noncompliance
	(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

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D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility no longer had a system in place to collect data on unusual incidents and investigations. Data were available for investigations involving abuse, neglect, and exploitation. The latest trend reports for incidents at the facility only included DFPS investigations. The facility was unable to review data in a timely manner to ensure that trends were addressed expeditiously because data were not compiled on a monthly basis. Information 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 gather accurate data and 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 needs to review various data collected in regards to incidents and investigations at the facility and ensure trend reports include accurate data. The facility did not maintain substantial compliance with this provision item.	Noncompliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm	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 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. Background checks were conducted on new employees prior to orientation and	Substantial Compliance

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	to individuals at the Facility.	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 12, criminal background checks were submitted for 431 applicants. There were a total of 8 applicants who failed the background check in the hiring process and therefore were not hired. Three employees had resigned due to results of background checks since the last review. 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. • Signed acknowledgement forms were submitted for 24 of 24 employees (100%). The facility remained in substantial compliance with this provision.	

Recommendations:

1. The facility needs to document all required notifications in the investigation file (D2a).
2. In order to send a clear message to all employees that abuse and neglect will not be tolerated, the facility needs to ensure that all incidents of failing to report by employees is addressed and that corrective action is immediate and appropriate (D2d).
3. The facility needs to ensure that documentation clearly reflects the time and date of investigative activities (D3e)
4. Efforts should continue to complete investigations within 10 days unless extraordinary circumstances exist (D3e).
5. Investigation documentation should indicate that all investigations are reviewed promptly by the facility to ensure that the investigation is thorough and complete and that the report was accurate, complete and coherent (D3g).
6. The facility needs to ensure that appropriate follow-up action is completed and documented in investigation files (D3g, D3i).
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 if data is accurate and 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 #003.1: Quality Enhancement, new policy revision, dated 1/26/12 o List of MSSLC facility-specific policies related to quality assurance (1 policy), Organizational Management-35 Participating in Quality Assurance and Improvement Council, revised 11/22/11 o Email from DADS assistant commissioner describing the formation of the statewide SSLC leadership council, 3/5/12 o Organizational chart, 3/9/12 o MSSLC policy lists, March 2012 o List of typical meetings that occurred at MSSLC, undated o MSSLC Self-Assessment, 2/21/12 o MSSLC Action Plans, 3/15/12 o MSSLC Provision Actions Information, 3/12/12 o MSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/26/12 o MSSLC DADS regulatory review reports, through 2/29/12 o H&W Solutions QA training handouts, January 2012 o Hogg Foundation Trauma-Informed training, February 2012 o MSSLC QA department meeting notes, October 2011 through March 2012 (11 meetings) o MSSLC QA process flowsheet, December 2011 o MSSLC data listing/inventory draft, undated, but likely March 2012 o MSSLC Quality Assurance Plan/matrix, undated, but most likely February 2012 o Set of blank tools used by QA department staff (2) o List of QA staff and each staff member's monitoring responsibilities o Some data, graphs, spreadsheets, and notes from some of the data collected at the facility o MSSLC CAPs tracking spreadsheet, March 2012 o 7 CAPs spreadsheets and implementation plans, December 2011 through March 2012, plus 2 additional implementation plans specifically for DADS regulatory follow-up, January 2012 o List of data to be reviewed at every PIT meeting o PIT meeting minutes and data, November 2011 through February 2012 or March 2012, 4-5 meetings for each of the five units o PIT meeting agenda and handouts for Whiterock and Martin meetings on 3/27/12 and 3/28/12 o PET meeting minutes, October 2012 through March 2012, 4 PET groups, 5-6 meetings each o PET II meeting agenda and handouts for 3/28/12 meeting o QAQI Council agenda and meeting minutes 9/22/11 through 3/15/12 (20 meetings) o QAQI Council agenda and handouts for 3/29/12 meeting o Executive Management Team meeting agenda and handouts for 3/27/12 meeting o DADS SSLC family satisfaction survey, cumulative since last onsite review, 17 participants o Self-advocacy meeting minutes, October 2011 through February 2012 (5 meetings)

	o Notes from home meetings, February 2012 (two from every home) o Recent facility newsletters, Focus, January 2012 through March 2012 Interviews and Meetings Held: o Kim Kirgan, Interim Director of Quality Assurance o Iva Benson, DADS Field-Based Operations Coordinator o Barbara Shamblin, Bertha Allen, John Parks, Troy Miller, Polly Bumpers, Residential Unit Directors o Terri Moon, Human Rights Officer Observations Conducted: o PIT meetings: Whiterock, 3/27/12, Martin, 3/28/12 o PET II meeting, 3/28/12 o QAQI Council meeting, 3/29/12 o Executive Management meeting, 3/27/12 o Self-advocacy meeting, 3/27/12 o Peer Council meeting, Whiterock-2, Barnett-6-7, 3/29/12
	Facility Self-Assessment: MSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. During the week of the onsite review, the monitoring team engaged in lots of discussion with facility staff regarding the new self-assessment. Facility staff appeared interested and eager to implement this new process correctly and in a way that would be beneficial to them. The most difficult aspect of this appeared to be understanding the somewhat subtle difference between assessing whether substantial compliance was met versus engaging in activities to meet substantial compliance. Determining how to assess the quality assurance provision items is a challenging task. Consider that much of what the QA department does is to help the departments self-assess their own performance (and to make changes, corrective actions, etc.). In reviewing the details of the QA, section E, self-assessment, the monitoring team noted that the QA director looked only at some data from the facility's data analyst for self-assessing E1, and "available data" to self-assess E2. For E3-E5, the QA director looked at the current set of seven corrective action plans.

	The monitoring team, however, recommends that the QA director review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the QA director to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." The monitoring team and the QA director engaged in detailed discussion about this during the onsite review. In addition, she should also work with the DADS central office QA coordinator and other SSLC QA directors on this task. As the QA director works on developing a self-assessment process for section E, she should consider these points: • Be comprehensive. Many provision leaders tended to rely primarily on the statewide self-monitoring tools and/or list of action plans. These tools can be one of the activities used to self-assess, but will not likely be sufficient for most provision items and the action plans may not always address everything that needs to be addressed. • Not self-rate substantial compliance solely on a score of over 70% on the statewide self-monitoring tools. • Be described in detail so that the reader can understand what it is that the QA director did. • Line up with what the monitoring team assesses as indicated in this report. The monitoring team looks at many things during its assessment of each provision item. Thus, the monitoring team recommends that the QA director review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. • Identify the samples chosen. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the QA director and believes that the facility was proceeding in the right direction. This was a good first step. The facility self-rated itself as being in noncompliance with all five of the provision items of section E. The monitoring team agreed with these self-ratings, however, as noted in the narrative report below, progress was evident since the time of the last onsite review.
	Summary of Monitor's Assessment: There was progress in the development of many aspects of a comprehensive QA program even though there was again change in the management of the QA department at MSSLC. The QA director should revise facility policies, based upon the new state QA policy. Also, given that the statewide policy was in development for more than a year, edits may already be needed. State office should consider this. The QA director had made real progress towards the creation of a list of all of the data collected at the facility. She presented an electronic spreadsheet that contained 23 tabs. Each tab was for an MSSLC

	clinical, service, or operational department and contained the data that the department collected. This was newly created, so it was not surprising that much more work needed to be done. Comments for the QA director as she develops this data list/inventory are in the report narrative. The QA Plan needed to be fully developed. It should consist of a number of components. The first component should be a narrative description of how QA is conducted at MSSLC. The second component should be the QA matrix. The QA matrix was initiated, though it hadn't changed much since the last review. Comments for the QA director as she moves forward in developing the QA matrix are in the report narrative. QA staff kept very busy. They spent their time collecting data using their department's two QA tools, completed statewide self-assessment tools primarily to assess interobserver agreement, and participated on various committees and in meetings. The monitoring team reviewed a number of completed tools. There was a need for improvement in inter observer agreement, especially regarding the correct definition of each items, and an assurance that the QA staff obtained inter observer agreement with the QA director. A great deal of time continued to be devoted to the implementation of the statewide Settlement Agreement self-monitoring tools. There are some important next steps in the use of these tools as described in the report narrative. A variety of satisfaction measures are important to include in the MSSLC QA program. A QA report did not yet exist at MSSLC. Only four sets of data were presented to the monitoring team. A series of QA-related meetings that were initiated by the interim facility director at the time of the last onsite review were continued by the newly appointed facility director. In PIT meetings, good information was presented and there was good discussion among participants. The unit directors reported that they found these reviews to be useful and a good use of their time. During the PIT meetings, the unit director wrote down actions and recommendations and then followed up on them at the next PIT meeting. At PET meetings, updates were presented by provision leaders, but there was not much participation and discussion at the meeting. Perhaps better sets of data graphs would be of more interest to the participants and lead to more interesting discussion among attendees. At the QAQI Council, there was good attendance and announcements of important information, but little in depth discussions. This is likely to develop over the next few months. MSSLC made good progress in managing corrective actions, especially corrective action plans. There were seven CAPs. Five were related to health care and nursing topics, one was for most integrated setting practices and the identification of obstacles to placement, and one was about the quality of skill acquisition programming. These CAPs spreadsheets had all of the required information in column format. As the QA director moves forward in further improving the CAPs system to meet the requirements of this provision item, as well as E3, E4, and E5, she should attend to the comments in the report narrative.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	Since the last review, there was again change in the management of the QA department at MSSLC. Even so, there was progress in the development of many aspects of a comprehensive QA program. This was due to the efforts of the Interim QA director, Kim Kirgan. Ms. Kirgan worked for a number of years in the QA department and was highly involved in the review of section E during the previous onsite review. As a result, in her interim role, she worked to initiate and implement some of the activities discussed during the last onsite review and that were recommended in the last monitoring report. Moreover, in the weeks following the onsite review, Ms. Kirgan was officially appointed as the new QA director. <u>Policies</u> The state's QA policy was finalized and disseminated. The new policy was titled #003.1: Quality Assurance, dated 1/26/12. The new policy provided detail and direction to QA directors and facility staff, much more so than did the previous policy. MSSLC had two or three facility-specific policies that were related to quality assurance. Now that state policy was disseminated, the QA director should revise these facility policies as appropriate. It is possible that some of these policies will no longer be needed, and/or that other new policies need to be created. Once facility-specific policies are developed, training and orientation of both the state and facility policies and their requirements needs to occur and should: • Be provided to QA staff. • Be required for senior management, including but not limited to QAQI Council. • Involve more than just the reading of the new policy. The new state policy also called for a statewide QAQI Council, and for statewide discipline QAQI committees. The statewide QAQI Council requirement was being met by the recent (3/5/12) formation of the statewide leadership council. Statewide discipline QAQI committees were not yet in place. Also, given that the statewide policy was in development for more than a year, edits may already be needed. State office should consider this. The QA director also talked about the need for a self-assessment tool for section E. This was not yet developed at either the state or facility level. The QA director's upcoming work towards an adequate self-assessment process for this provision will likely result in a self-assessment tool/process for section E.	Noncompliance

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		General QA Planning Listed below are important component steps in the development of a QA program. The monitoring team had the opportunity to discuss these at length with the QA director. She was aware of these and had initiated efforts to address them. These component steps were listed in the previous monitoring report, however, the detail is not repeated here. Instead, the reader should refer to previous monitoring reports. • Create a listing/inventory of all data collected at the facility that includes the variety of categories of data detailed in previous monitoring reports. • Determine which of these data are to be submitted to the QA department for tracking and trending (and to be part of the QA 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. • Create and manage corrective actions based upon the data collected, and direction from the QAQI Council. QA Department Ms. Kirgan, although experienced as a QA department program auditor, will have a new role as leader of the QA program. The facility will be looking to her for direction regarding quality assurance. The monitoring team has confidence in her ability to move the facility forward towards substantial compliance with this provision. To increase the likelihood of success, however, the QA director will need direction and assistance from both the facility director and the state office Quality Assurance coordinator. Furthermore, she may benefit from a mentoring relationship with another facility's QA director. Also important will be her working collaboratively with the Settlement Agreement Coordinator (SAC). The MSSLC SAC, Etta Jenkins, was very competent, experienced, and knowledgeable about the Settlement Agreement and the facility. The QA department continued to have bi-weekly department meetings as recommended and noted in previous reports. The agendas and topics appeared to be relevant. As discussed with the QA director and as also recommended in the previous report, these meetings should include topics about quality assurance rather than only being used to make announcements. In other words, the meetings should be used as a staff training-type of opportunity, so that staff can learn about the profession of quality assurance, participate in creating processes for the department and facility, and so forth. Quality Assurance Data List/Inventory The creation of a list of all of the data collected at the facility is an important first step in the development of a comprehensive quality assurance program. The QA director had	

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		made real progress towards this. She presented an electronic spreadsheet that contained 23 tabs. Each tab was for an MSSLC clinical, service, or operational department and contained the data that the department collected. This was newly created, so it was not surprising that much more work needed to be done, but the monitoring team was glad to see good progress. Below are some comments for the QA director as she develops this data list/inventory further. • The lists under each department tab were not yet completed, that is, additional items needed to be added, including, for example, the types of data presented in the PIT meetings. It will probably take a few more months to obtain a more comprehensive list. Some disciplines/departments listed only the use of the statewide self-monitoring tools when there were certainly other types of data that they collected. • The list/inventory should be a simple list. It does not need to (<u>but certainly can</u>) include all of the additional columns that were in this list (e.g., follow-up, auditing, data responsibilities, QAQI). Remember, the goal is to have a simple listing that can be easily read by QAQI Council members as well as any other interested parties. Further, clinical and operational staff may be more likely to contribute to the list if it is easy to do so. (The additional columns, however, are needed for the QA plan matrix, see below.) • Sometimes the type of data was recorded in the "Other" column whereas sometimes it was recorded in the "Auditing-Audit Tools" column. This should be made consistent. • MSSLC should develop a set of data measures related to the forensic population served there, including, but not limited, to peer to peer aggression. The psychology department, as well as some of the information from the recent training from the Hogg Foundation on trauma-informed supports, might be helpful in identifying relevant measures. o Peer to peer aggression was noted as a problem in many different forums during the onsite review and in many of the documents reviewed by the monitoring team. Sometimes there was peer to peer aggression that resulted in injury, sometimes there was no injury. QA should bring the topic of peer to peer aggression to QAQI Council for consideration of a performance improvement project or facility improvement team to address this cross-discipline issue. <u>Quality Assurance Plan and Matrix</u> The QA Plan should consist of a number of components. The first component should be a narrative description that might include a two or three page overall description of how QA is conducted at MSSLC; a description of the comprehensive inventory listing of all data that are collected across the facility; a description of the QA matrix and how those	

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		data are managed, reviewed, trended, and analyzed by the QA department; the role of any QA databases; the way that the PIT-PET-QAQIC meetings work; and the overall expectation and processes for data analysis, corrective action planning, and corrective action management. The QA director also presented a one page MSSLC QA process flowchart. It was a good description of one aspect of the QA process, that is, the collection of a sample of data on a set of indicators, such as the statewide self-monitoring tools. The QA director could consider including this flowchart (or a version of it) in the narrative of the QA plan. Note, however, that the collection of a sample of data is not the only QA process. There is the development of the data listing, reviews by QAQI Council, etc. The second component should be the QA matrix. It should be attached to the narrative, thereby, creating the QA plan. The QA director included the QA matrix as a tab in the electronic spreadsheet described above. This made sense to do because the items in the QA matrix were all to be chosen from the items in the overall listing/inventory. Below are comments for the QA director as she moves forward in developing the QA matrix. • All items in the QA matrix are data that are to be submitted to the QA department and analyzed by the QA department. Some of the summarizing and graphing of the data, however, can be done by the discipline/department prior to submission to the QA department (see E2 below). • The selection of what items are in the QA matrix should come from: o QAQI Council, o Clinical, service, and operational department heads, and o The QA director. • Typically, the selection will result in a number of "types" of items, such as: o A list of tools to monitor each of the provisions of the Settlement Agreement. Usually, this is the statewide self-monitoring tools, plus any other self-monitoring tools used by the department. o A list of data that the QAQI Council wants to see. In some facilities, these are called key indicators. o A list of data that the QA staff collect themselves. o Any other data that the QA department wishes to receive from the facility's many departments. o Any data that the discipline department heads determine are important to submit to the QA department. • Make sure that there are no items in the QA matrix that do not also appear in one of the discipline/department tabs.	

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		• The additional columns that described the auditing and data responsibilities should continue to be included. In addition: o Add a column to describe what the actual data metric is, such as number, score, percentage, etc. That is, the data that would be presented for that item. <u>QA Activities and Indicators</u> The QA director maintained a simple one-page listing of each QA staff member and his or her activities and responsibilities for data collection, monitoring, and meeting attendance. QA staff spent their time collecting data using their department's two QA tools, completed statewide self-assessment tools primarily to assess interobserver agreement, and participated on various committees and in meetings. The QA department led periodic, as-needed, meetings if issues arose that indicated a need. These were called QA critical incident meetings. Three had occurred since the last onsite review. Two were on 12/7/11 (to address drugs on campus and transfers to other SSLCs) and one was on 3/8/12 (to address an injury to one individual). This was a good activity for the QA department to conduct and the QA director should continue to do so when necessary. The three meetings were included in the QA department meeting minutes, however, a cumulative written log is recommended, so that their history and outcomes do not get lost once the information drops off of the QA agenda and minutes. There were two QA tools that were completed by QA staff. The first was called the Quality Assurance Monitoring form, revised on 1/27/12, and recently re-implemented with a goal of 25 per month. It was one page with 23 relevant items, divided into four topics. Ten forms completed in February 2012 were reviewed by the monitoring team. Two different QA staff each completed five of the 10. All were done on Martin or Longhorn only. Interestingly, for one QA staff, every item was scored yes on every form, whereas for the other QA staff, there was at least one item scored no on each of the five forms. This begged the need for interobserver agreement checks between QA staff members. The second tool was called the MSSLC Active Treatment Monitoring and Coaching Guide, revised 12/20/11. It was two pages, had 27 items, was revised from a previous version that had 43 items, and had nine relevant sections. According to the QA director, the tool was used by various managers and supervisors, including the 3-11 supervision team, with a goal of 240 implementations per month. The monitoring team reviewed nine completed forms. These were done by four different raters, and the QA director completed one of the nine, too. Interestingly, in the one form completed by the QA director, there were six items scored no, whereas across the eight other completed forms, there were a total of six items recorded no. This again begged the question of	

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		inter rater agreement across QA staff and, furthermore, whether QA staff were following the proper definition. For instance, it could be that two QA staff would get high inter-rater agreement with each other, but neither would have good agreement with the QA director. Across the facility, a great deal of time was devoted to the implementation of the statewide Settlement Agreement provision self-monitoring tools. There are some important next steps in the use of the statewide tools. • First, the content of the statewide tools should be updated so that they are relevant and valid. Facility managers and clinicians were recently given the option of doing so by state office. • Second, consideration should be given to the frequency of completion of each tool. Some might only need to be completed periodically. • Third, some items in each tool may be more important than others. These should be indicated. • These tools should be one of many components of the self-assessment procedures used by each of the departments. A document called the Trend Analysis did not appear to be used at the facility or by QA as it had been in the past. This appeared to be due to changes in the state's data entry and reporting system. The Trend Analysis summarized and graphed data for restraint usage, ANE allegations and findings, unusual incidents, and injuries. The monitoring team's understanding, however, was that these four data sets were to be continued and that they would be in place for the next onsite review. As discussed in previous reviews, a variety of satisfaction measures are important indicators to include in a comprehensive QA program. Family and LAR satisfaction information was collected since the last onsite review, however, there were only 17 respondents, 13 of whom were from Martin and Barnett, two from Whiterock, two from Longhorn, and none from Shamrock. The data were not summarized or reviewed by MSSLC managers. Also, the bar graphs of individual questions should show the number of responses to each question, not only one bar graph that shows the average score. The comments for each question and the two open-ended questions at the end also provided potentially valuable information. Measures of individual satisfaction might be obtained via self-advocacy committee and/or the weekly peer home meetings. Both types of meetings were observed by the monitoring team. The self-advocacy group made good progress in the past two or three months in increasing attendance and choosing relevant topics for each meeting. The home peer meetings were also regularly occurring. The meeting observed on Whiterock-	

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		2 was led by the dynamic house manager. There was good participation from the six individuals who attended. The monitoring team planned to also observe a meeting on Barnett, but it never occurred. After these observations and a review of the notes from recent meetings, the monitoring team recommends that many of these home meetings move to working on group decision making and group problem solving activities. Perhaps the human rights officer, psychology department, and/or master teachers can assist with designing and implementing this. Satisfaction measures should also extend to staff, and others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth. The QA director should figure out a simple way to include satisfaction data in the QA data listing and QA matrix.	
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.	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. The activities that are relevant to this provision item are the facility's management and analysis of data, the QA report, the QAQI Council, the use of performance improvement activities, and the management of corrective actions and corrective action plans. Progress was seen at MSSLC. <u>QA Data Management and Analysis</u> The data that come into the QA department (i.e., the items on the QA matrix) need to be reviewed by the QA department (probably primarily by the QA director) <u>and</u> they need to be summarized. This was not yet occurring. Summarizing of data is typically done in the form of a graph or a table. Most typical, and most useful, will be a graph. To repeat from the previous report, 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. A proper graph takes time to initially create, but after that, only requires an additional data point to be added each month, quarter, etc. Note that 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 data and graphic summaries each month (as the QA nurses were already doing). Many of these graphs can be inserted into the QA report and be presented to QAQI Council. Only four sets of data were presented to the monitoring team. Comments for each of the four are below. • A single-page bar graph showed the average scores for the statewide self-	Noncompliance

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		monitoring tools for the three-month period December 2011 through February 2012. Overall, the scores were extremely high; only four were below 80%. Please see comments in E1 above regarding these tools. • Tables, lists, and graphs for the active treatment monitoring and coaching guide tool all showed high scores of over 90%. The attached narrative, a descriptive, somewhat item-by-item analysis of 75 completed tools provided some useful information. This analysis may have led to the revision of the tool that made it shorter and easier to implement. Also see comments regarding this tool in E1. • A single bar graph summarized the topics of more than 200 suggestion box items since 2010. This was good to see and was in response to a recommendation in previous monitoring reports. The next step is to use the summarized information, if possible. • A tracking tool spreadsheet for recommendations that came out of investigations was recently created. This was a good idea. Now that the spreadsheet was created, summary data should be kept, such as number of outstanding recommendations at the end of each month, and number of completed recommendations at the end of each month. <u>QA Report</u> A QA report did not yet exist at MSSLC. The monitoring team and the QA director spoke about considerations when developing the MSSLC QA report over the next few months. One important consideration is to make the report easily consumable by those who will be required to read it. <u>QA-Related Meetings</u> MSSLC continued to hold a series of QA-related meetings that were initiated by the interim facility director at the time of the last onsite review and were continued by the newly appointed facility director. • <u>Performance Improvement Teams</u>: PIT meetings occurred once per month per unit and were led by the unit director. At this unit-level meeting, four sets of data were presented (nurse, QDDP, psychologist, and master teacher). The monitoring team attended two of these meetings. Good information was presented and there was good discussion among participants. The unit directors reported that they found these reviews to be useful and a good use of their time. During the PIT meetings, the unit director wrote down actions and recommendations and then followed up on them at the next PIT meeting. o Consider modifying the set of data presented to meet the specific needs of each unit's population rather than having an identical set of data. o Consider adding some small graphs under the tables that have month to month data to show trending. This may be of use to the participants.	

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		o There was confusion regarding a few of the items: ▪ Whether the referral data meant referred for a guardian or referred for community placement. ▪ Whether every individual who was risk-rated at high and medium needed to be listed, or only those for whom the IDT took any new actions related to managing these risks. • Performance Evaluation Team: The 20 provisions of the Settlement Agreement were divided into four groupings, each was called a PET. Each PET met monthly and the provision leader presented the facility's status on that provision. The provision leader used a nine-item format called the monthly provision action information worksheet to guide his or her presentation. Each PET meeting was led by the SAC. The monitoring team attended the PET II meeting. Unfortunately, there was not much participation and discussion at the meeting, merely presentations of information by the provision leader. Perhaps better sets of data graphs would be of more interest to the participants and lead to more interesting (and more likely useful) discussion among attendees. Interestingly, the SAC raised the topic of moving PET meetings to quarterly rather than monthly. This seemed to be a reasonable proposal. • QAQI Council: This meeting plays an important role in the QA program and is to be led by the facility director. Since the last onsite review, there had been two interim facility directors; the new facility director was appointed only a few weeks prior to this onsite review and, as such, had not led a QAQI Council prior to the week of the onsite review. There was good attendance at the meeting, announcements of important information, but little in depth discussions. This is likely to develop over the next few months. Facility Improvement Teams MSSLC made some use of facility improvement teams, work groups, and special project activities. These should be brought more formally under the QAQI Council. Corrective Actions MSSLC made good progress in managing corrective actions, especially corrective action plans. Some corrective actions were called plans of correction (if for a DADS regulatory activity) and sometimes were called a corrective action plan (CAP), if for actions related to the Settlement Agreement, facility management, or DADS regulatory activity. The CAP process included a two-page handwritten completed form that helped the CAPs developer cover lots of important topics, as well as obtaining signatures of department and QA staff. The information from this two-page form was put into a spreadsheet for that specific CAP. The monitoring team recommends that an item be added in regards to having the CAPs developer recommend whether any policy changes should be	

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		considered. There were seven CAPs. Five were related to health care and nursing topics, one was for most integrated setting practices and the identification of obstacles to placement, and one was about the quality of skill acquisition programming. These CAPs spreadsheets had all of the required information in column format. As the QA director moves forward in further improving the CAPs system to meet the requirements of this provision item, as well as E3, E4, and E5, she should: • Clearly indicate, perhaps in the QA plan: o How a determination is made for there to be corrective action, o How the determination is made as to whether that corrective action will require a formal CAP, o The role of QAQI Council in the management of a CAP, and o The role of the QA department in the management of a CAP. • Ensure that the expected outcomes are written in a clear and measureable manner that is related to the reason for there to have been a CAP. For example, some of the expected outcomes only referred to an increase in scores on the statewide self-monitoring tool. • Have documentation describing the progress of CAP implementation and modification. • When a CAP is concluded, write a summary description of the status of the issue that led to need for the CAP. Finally, as also written in section L2 regarding the facility's development of a medical quality assurance program: The facility must be cautious about implementing corrective actions that do not address the underlying problems. This is where the appropriate use of performance improvement methodology and root cause analysis demonstrates its greatest value. The facility must ensure that corrective actions have adequately addressed the issues/root causes that resulted in compliance low compliance scores.	
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	MSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

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	the problems originally identified.		
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. Revise, create, and/or eliminate facility-specific policies now that the state policy is approved and disseminated (E1).
2. Provide training to QA staff, and senior management and clinical staff on the new state policy and any QA-related facility-specific policies. Training should involve more than the reading of the policies (E1).
3. Implement the statewide discipline QAQI committees, as per the new state policy (E1).
4. Consider whether the state policy might need any updates or revisions (E1).
5. Ensure that the new QA director gets support from the facility director and central office quality assurance coordinator; possibly mentoring from another experienced QA director (if deemed appropriate to do so by the central office quality assurance coordinator and the MSSLC facility director; and collaboration from the SAC (E1).
6. Include professional development activities for QA staff during the QA staff meetings (E1).
7. Complete an initial complete and comprehensive listing/inventory of all data collected at MSSLC. Develop metrics specifically relevant to the forensic population, including for example, peer to peer aggression (E1).
8. The QA director should bring the facility-wide issue of peer to peer aggression to QAQI Council for consideration of a CAP and/or facility improvement team (E1).
9. Make an appropriate QA plan, with a narrative as described in E1 (E1).
10. Make sure the QA matrix is comprehensive, and add a column to indicate the specific metric that will be used (E1).
11. Keep a log of QA critical incident meetings and follow-up (E1).
12. Do inter observer agreement checks with QA staff and include the QA director for the two QA department tools (E1).
13. Along with state office guidance, determine how to best use the statewide self-monitoring tools and whether/how to update their content (E1).
14. Include a range of satisfaction measures in the QA program (e.g., family, individuals, staff, and related community businesses) (E1).

15. Improve peer home meetings to address skills, such as group decision making and group problem solving, in those homes where this would be appropriate to do so (E1).

16. Review and summarize (e.g., graph) all data in the QA matrix (E2).

17. Create a QA report (E2).

18. Consider the PIT recommendations in E2 (E2).

19. Consider ways to set the occasion for more in depth discussion during PET meetings (E2).

20. Determine how to use facility improvement teams (E2).

21. Address the bulleted recommendations regarding CAPs in E2 (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:** <u>Documents Reviewed</u>: o Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o DADS Procedure: Personal Focus Assessment dated 9/7/11 o MSSLC Self-Assessment o MSSLC Section F Presentation Book o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews for the following Individuals: • Individual #244, Individual #431, Individual #53, Individual #31, Individual #560, Individual #151, Individual #519, Individual #500, Individual #491, and Individual #313. <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Pat Samuels, Incident Management Coordinator o Charlotte Kimmel, PhD, Director of Psychology o Valerie McGuire, QDDP Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 3/27/12 and 3/29/12 o Human Rights Committee Meeting 3/27/12 o Shamrock PIT Meeting 3/28/12 o Restraint Reduction Committee Meeting 3/28/12 o 2nd Quarterly Review Meeting for Individual #477 o Annual ISP meeting for Individual #51 o Annual ISP meeting for Individual #120
	Facility Self-Assessment: MSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement. The facility reported that it was focusing on deficits 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.

	For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. The "activities engaged in" section of the self-assessment noted use of the section F monitoring tool for most provisions in section F. The results of the self-assessment section gave a brief description of the sample size and a compliance percentage. The facility did not include a description of the sample, so it was not possible to determine what the facility looked at to determine compliance. The list of activities engaged in by the facility was not as comprehensive as activities reviewed by the monitoring team to assess compliance. For example, for F1b, the self-assessment noted that the facility had selected a sample size of 14 for the quarter and determination of compliance was made using the section F monitoring tool. The monitoring team reviewed what supports and services were needed by the individual to determine who would be a relevant team member, then additionally, looked at whether or not team members came to the meeting with information needed to participate in an informed discussion. To take this process forward, the monitoring team recommends that the QDDP Coordinator review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the QDDP Coordinator to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the QDDP Coordinator. This was positive progress. The facility assigned a noncompliance rating to all items in section F. Though progress had been made in regards to meeting substantial compliance with section F, the monitoring team agreed with these self ratings.
	Summary of Monitor's Assessment: DADS had recently initiated a thorough review of the ISP process and hired a set of consultants to help the SSLCs move forward in ISP development and the meeting of this provision's requirements. Comments are more generalized for section F in this report in light of the fact that MSSLC had not yet received technical assistance from consultants. The facility had not begun implementation of the new ISP process. Three of the four annual IDT meetings scheduled during the review week were observed by the monitoring team. In meetings observed during the review week, the QDDPs were attempting to ensure that all necessary information was covered during the IDT meeting. It was noted, however, that discussion was not

	adequate in most areas. As noted in section I, the risk discussion was not leading to the accurate identification of risks and development of action plans that staff could follow. Teams were not adequately addressing guardianship and consent, community integration, or placement options. There was little progress being made on developing plans that would lead to a more meaningful day for individuals. IDTs were still building plans around programming that was available at the facility rather than looking at what each individual may need or want. The monitoring team had the opportunity to observe numerous meetings held at the facility during the review week. It appeared that an inordinate amount of time was spent meeting to address refusals to comply with treatment plans. Developing programming in response to preferences and individualized support needs would likely have a significant impact on the number of refusals to participate in treatment and programming. 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. Quality assurance activities with regards to ISPs were in the initial stages of development. The facility had begun to use state developed audit tools to review both meeting facilitation and the ISP development process. 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 IDT. The ISPs that were reviewed were chosen from among the most recently developed ISPs. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and IDTs had been responsible for the development of the plans. As noted throughout section F, assessments were still not completed or updated as needed, key members of the team were not present at annual meetings, plans still did not integrate all services and supports, and plans were not consistently implemented and revised when needed.

#	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:		
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.	QDDPs had recently been assigned responsibility for facilitating IDT meetings at the facility. In the past, each team had been assigned an ISP Coordinator to facilitate meetings. The ISP Coordinators were mentoring QDDPs during the initial stages of this change in process. QDDPs were at varying stages in learning to competently facilitate meetings that encouraged integrated discussion adequate for developing appropriate supports. The QDDP Coordinator was attending a sample of IDT meetings and evaluating the QDDP's facilitation skills using the Q Construction QMRP Facilitation Skills Performance Tool. Additionally, DADS had hired a team of consultants who were providing classroom training, coaching, and mentoring to the IDTs on facilitation skills and ISP development. The consultants had not yet provided technical assistance to MSSLC. Meetings observed during the monitoring visit confirmed that QDDPs were facilitating ISP meetings with assistance from the ISP Coordinators. A sample of 10 IDT attendance sheets was reviewed for presence of the QDDP at the annual IDT meeting. At all annual meetings, there was a QDDP present. The QDDPs were also responsible for ensuring that team members were developing, monitoring, and revising treatments, services, and supports. The facility's self-assessment indicated noncompliance with this requirement based on audit findings. The facility found that assessments were not timely for inclusion in planning process in 66% of the sample audited. This finding is discussed further in F1c. This will be a necessary component in gaining substantial compliance with F1a. While progress had been made towards meeting substantial compliance, it will be important for the QDDPs to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to address all risk that teams identify. An adequate assessment process will need to be in place to ensure all supports are addressed by the team. DADS reported that it was continuing to work on describing and defining the aspects of facilitation that should be demonstrated by the QDDPs.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 IDT meetings. The sample included ISPs for the following individuals: Individual #244, Individual #431, Individual #53, Individual #31, Individual #560, Individual #151, Individual #519, Individual #500, Individual #491, and Individual #313. Seven (70%) of 10 indicated that the individual attended the meeting; • The exceptions were Individual ##53, Individual #560, and Individual #500. Two of the individuals in the sample had a guardian. One (50%) of two participated at the annual IDT. • The exception was Individual #491. The monitoring team does not expect that all individuals or their LARs will want to attend their IDT meetings. When individuals are not present for meetings, the QDDP should document attempts made to include the individual or LAR and how input was gathered to contribute to planning if the individual did not attend the meeting. When individuals consistently refuse to attend meetings, the team should look at what factors contributed to the refusal to attend and brainstorm ways to encourage participation. A review of 10 signature sheets for participation of relevant team members at the annual IDT meeting indicated that six (60%) of the meetings were held with <u>all</u> relevant staff in attendance. There was improvement in attendance at meetings by relevant disciplines. At the last onsite review, it was found that only 10% of the ISPs in the sample were developed by a full team. There was no documentation included in any of the IDTs that would indicate input was given prior to the meeting by staff that were unable to attend the meeting. Some examples where team participation was not found to be adequate were: • A review of the attendance sheet for Individual #431 indicated that vocational staff, psychiatric staff, his dietician, and communication therapist were not present. Professional staff should have been in attendance to contribute their expertise in developing appropriate supports to address his identified risks and ensure adequate programming was in place. • Individual #560 was rated as high risk for weight concerns. His dietician was not in attendance at his annual meeting. His risk assessment, nursing assessment, and ISP included conflicting data in regards to his caloric intake and weight history. It was not evident that a nutritional assessment had been completed prior to his ISP meeting. • Individual #491's psychiatrist was not present at her annual IDT meeting. She	Noncompliance

#	Provision	Assessment of Status	Compliance
		was at high risk for polypharmacy because she was being treated with multiple psychotropic medications. She had a multiple psychiatric diagnoses and was the subject of frequent restraints. The psychiatrist should have been involved in interdisciplinary planning for her. • Individual #518 had complex healthcare needs. Her diagnoses included GERD, osteoporosis, diabetes, blindness, hypertension, paroxysmal atrial fibrillation, periodontal disease, and chronic anemia. She was hospitalized for 25 days over the past year. Her g-tube was replaced multiple times this year due to blockage and inadvertent removal. She had been treated for a fractured femur, pneumonia, UTI, and Stage 1 decubitus ulcers. Additionally, she communicated nonverbally. Her physician and SLP did not attend her annual IDT meeting. Her team determined that she was not at high risk in any health related areas. Her physician could have guided the team in discussion to accurately identify her risks and develop a plan to address any risk areas. While all relevant disciplines were in attendance at the IDT meetings observed the week of the review for Individual #51 and Individual #120, team members did not come prepared with accurate information to adequately assess his risks and develop supports based on Individual #120's current health status. For example, she was at risk for respiratory complications. The team did not have data regarding her oxygen levels or how often her breathing was being monitored during the night. Her most recent lab results were not included on her risk assessment or readily available. Individual #51's team did not have significant health history information that impacted her risk ratings. Her mother was able to provide information to the team at the meeting. The absence of key members was a significant barrier to integration in the development of ISPs. 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. IDTs were determining who needed to be present at the annual IDT meeting during the third quarterly review meeting based on the results of the PFA. This process was new, but should have a positive impact on meeting participation. During psychiatry clinics, the IDT process was evident in that there was discussion among the team with regard to behavioral challenges and other issues. The QDDP could complete ISPA documentation for these gatherings, too. The self-assessment indicated that the facility was not yet in compliance with requirements for integrated team participation. The monitoring team agreed.	

#	Provision	Assessment of Status	Compliance
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	Steps the facility had taken to improve the assessment process used for planning included: • The facility was using a database to track submission of assessments prior to the annual ISP meeting. • The QDDP educator was now tracking submission of assessments prior to annual team meetings and sending notification to discipline heads when assessments were not submitted on time. • Change of status for individuals was being identified in the daily unit meetings. The monitoring team found the quality and timeliness 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 ISP, 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). For example, the ISPs of the majority of the 25 individuals reviewed (see section M) failed to accurately portray their health status and needs. Thus, many individuals ISPs lacked strategies and interventions to address their current, active medical problems and health risks. The PFA was an assessment screening tool used to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. In the ISPs reviewed, the PFA was used to develop a list of priorities and preferences for inclusion in the annual ISP. The PFA format had been revised 9/7/11. The facility was now using the new PFA assessment. PFAs were now being completed at the third quarterly meeting prior to the annual IDT meeting. PFAs reviewed in the sample, confirmed that this was routinely occurring. The list of preferences developed from the PFA process was reviewed for eight individuals. Teams were at varying stages in developing a list of priorities and preferences that could be used for planning. Eight of the ISPs developed after 12/1/11 were reviewed to determine if the list of preferences was adequate for planning. The following are comments regarding those ISPs. • Seven were individualized and based on current assessments. The exception	Noncompliance

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		was the ISP for Individual #560. His list of preferences only included playing his keyboard, smoking cigarettes, and watching television. His previous ISP included a much more comprehensive list of things that he enjoyed. • None (0%) described preferences for daily schedules. Given the high number of refusals and aggression towards others at the facility, this type of information would be critical for support staff to know. Structuring an individual's day and environment to encourage participation often relies on 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 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 prefer to spend time alone in the evenings or socialize with friends? o Does the individual prefer assistance from particular staff members? • The list of preferences for Individual #500 was the most comprehensive in the sample. The team touched on his preferences in numerous areas, including relationships, activities, environment, and support provided during daily living skills. • The list of preferences in the ISP did not include all preferences noted in the PFA for individuals in the sample. For example, Individuals #431's ISP did not include that he liked to read the Bible and loved stories; wanted to learn to cook; enjoyed going to Wal-Mart, the library, computer lab and canteen; preferred to wear cowboy boots or Nikes; liked to keep his hair short; and liked to work on the road crew, in the green house, or in the woodshop. Information gathered from the PFA was discussed in the IDT meetings observed. Each QDDP reviewed the individual's list of preferences and members of the team engaged in limited discussion on how these might be supported. Teams should use this list of preferences to brainstorm ways individuals might gain greater exposure to new activities that might be of interest. Consideration of outcomes was limited based on activities available at the facility. Outcomes should be considered that might lead to greater exposure to the community. The facility was using the Functional Skills Assessment (FSA) to assess each individual's functional skills. The FSA will not be beneficial to teams if it becomes a rote checklist to be completed annually. Staff completing the assessment will need to put thought into information gathered from the assessment and make recommendations that will assist the team in planning. FSAs were reviewed for Individual #244, Individual #53,	

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		Individual #431, Individual #31, and Individual #313. None of the FSA assessments in this sample included specific recommendations for training. Staff were completing the checklist, but not using it to develop individualized recommendations from the results. The facility self-assessment noted that for a sample of 14 ISPs reviewed October 2011 through December 2011, assessments were not submitted timely 66% of the time. The facility rated F1c as not in compliance. The self-assessment did not look at the adequacy of assessments submitted. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning. Assessments should result in recommendations for support needs when applicable. The facility was not in compliance with this item.	
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.	Some of the more recently developed ISPs offered much clearer directions for providing supports and services based on assessment recommendations. For example, the ISP for Individual #53 included a fairly comprehensive list of support needed throughout her day with easy to follow instructions for DSPs. This was good to see. It was not evident in the sample reviewed that assessments were always used to revise protections and supports, as necessary. For example: • Individual #560's previous OT assessment indicated that he was wearing shoes much smaller than his foot size and recommended purchasing him the right size shoe. His current ISP noted that he was still wearing the wrong size shoe according to his current OT assessment. • Individual #53 was rated at medium risk for falls and fractures. Her assessments showed that she was blind, needed assistance with ambulation, and had experienced a fall in the past year. She also had a diagnosis of osteoporosis. She was at high risk for falls and fractures according to information included in her assessments. The team rated her as a medium risk. • Individual #491's team met 11/23/11, 11/8/11, 10/21/11, 10/13/11, 10/10/11, and 10/5/11 to review restraint incidents. ISPAs for each date recommended continuing her enhanced level of supervision. Alternate treatment was not recommended by the team. The facility was not yet in compliance with this item. QDDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and information from assessments is used to develop plans that integrate all supports and services needed by the individual. Plans should be clear and easy to follow for all non clinical staff responsible for providing daily supports.	Noncompliance

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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).	DADS Policy #004: Personal Supported Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual ISP meeting, at minimum. A sample of 10 ISPs was reviewed for indication that individuals and/or their LARs were offered information regarding community placement, as required. This included the ISPs for Individual #244, Individual #431, Individual #53, Individual #31, Individual #560, Individual #151, Individual #518, Individual #500, Individual #491, and Individual #313. • In 10 (100%) this discussion took place at the annual IDT meeting. As evidenced by the summary below, this discussion, however, was not always adequate (also see section T of this report). • The ISP for Individual #431 noted that he would remain at MSSLC until he was behaviorally stable to be referred for community placement. There was no indication what that might look like or how the team would measure stability. • The ISP for Individual #53 indicated that her main obstacle to living in a less restrictive setting was that she was not consistent in expressing where she wanted to live. She had toured group homes in the past, but the team recommended that she continue touring additional group homes. The team should consider some longer trial visits to give her a better understanding of her options. In the discussions at the IDT meetings observed by the monitoring team, the community living options discussion was much more in-depth and meaningful than portrayed in the ISP document. QDDPs appeared more comfortable discussing living options with the IDT. QDDPs involved other team members in an integrated discussion regarding the most appropriate placement. This discussion, however, did not lead to the development of meaningful outcomes. There were some common themes among the discussion and determination of most integrated setting placement and programming in the ISPs reviewed: • Community integration and employment was not adequately addressed in any of the ISPs reviewed or at any of the IDT meetings observed. • Measurable action plans with reasonable timelines for completion were not developed when IDTs agreed that placement in a least restrictive environment would be an appropriate consideration. • Outcomes addressing community awareness were not based on priorities identified by the team and were not functional in the community.	Noncompliance

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		IDTs need to give consideration to the following: • The primary focus of all IDTs should be to provide training and supports that would allow each individual to live in the most integrated setting possible. • Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility when these are identified as barriers to living in a less restrictive setting. • Team members need to be provided with updated training on services and supports that are now available in the community. The facility's self-assessment indicated that a workgroup had been established to assist the IDTs in locating meaningful learning opportunities, jobs, and relationships. ISPs continued to address community integration via action plans and learning objectives. This process was very new and it was not yet evident that recommendations from the workgroup were helping teams to develop more meaningful plans. For example, in one of the more recent plans developed (1/10/12), only one outcome specifically addressed training in the community and it was more of a general statement than a functional outcome to achieve a desired objective. The outcome was to be given opportunities to go into the community to attend the ACE center, go shopping, and attend other events. Plans included limited opportunities for community based training. No plans included opportunities to develop relationships and gain membership in the community. Although the facility reported that some training was occurring in the community, it was not evident in ISP outcome documentation. Plans will need to include community based teaching strategies to ensure that training is functional, 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		

#	Provision	Assessment of Status	Compliance
	and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The self-assessment indicated that a corrective action plan had been developed to address F2a1 due to recurrent low compliance scores in this area. The ISPs in the sample continued to include a list of the individual's preferences and interests. For individuals in the sample, this list was used as the basis for outcome development. Limited exposure to new activities, however, meant that this list was often limited. In order to meet compliance requirements with F2a1, IDTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. Observation did not support that individuals were spending a majority of their day engaged in activities based on their preferences. ISPs reviewed were reflective of the lack of options and programming. While some plans included opportunities to take trips to the community, as well as minimal training opportunities in the community, no plans presented opportunities for participation in a manner that would support continuous community connections, such as friendships and work opportunities. Meaningful supports and services were not put into place to encourage individuals to try new things in the community. Some examples are noted above in F1e. The facility was not in compliance with this item.	Noncompliance
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet 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. ISPs 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. Specific behavioral indicators should be identified to determine successful implementation. For example: • Individual #53's SPO included instructions stating "has a BSP and it should be integrated into her training." There were not specific instructions for integrating recommendations from her BSP into her training strategies. • Individual #31's risk action plan did not include indicators for DSPs to monitor. For example, his action steps to address his high risk for falls noted that he had a PRN wheelchair and gait belt with no instructions for when staff should offer those supports. His risk action plan for UTIs stated review overall risk of urinary tract infection. There were no staff instructions for monitoring indicators.	Noncompliance

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		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.	
	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. PNM, healthcare management plans, and dining plans were not submitted as part of any of the ISPs in the document request. These plans should be attached to the ISP and considered an integral part of the plan. The facility self-assessment process found that assessments were not always submitted 10 days prior to the annual IDT meeting and in some cases, not submitted until after the meeting, so integration of all plans was not possible. When developing the ISP 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. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	For the goals and objectives identified, ISPs described the timeframes for completion and the staff responsible. Completion dates were based on the date of the annual team meeting rather than the expected learning rate of the individual. Methods for implementation were not always adequate, as is discussed in further detail in section S below. 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 at the Facility and in community settings; and	The facility had made little progress towards compliance with this item. As noted throughout the report, plans did not always adequately address supports needed by the individual to achieve the outcomes. Minimal functional learning opportunities were included in the ISPs in the sample. 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. Training provided in the day programs observed throughout the monitoring visit did not support that training was provided in a functional way. Few training opportunities were offered in a natural setting, such as the home or community.	Noncompliance

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		There were constraints on training opportunities because individuals were living at a facility rather than in the community. For instance, individuals did not participate in meal preparation and service. They 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. Interventions, strategies and supports did not adequately address individual's needs and many were not practical and functional at the facility and/or in community settings.	
	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.	ISPs identified the person responsible for implementing service and training objectives and the frequency of implementation. ISPs also included a column to note where information should be recorded. 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. The facility had a monthly and quarterly review process in place. It was not evident that the team considered modifying outcomes based on data collected. Reviews did not always offer a summary of data. For example, a monthly review of training for Individual #491 noted that she had "met her baseline and was on task, however she remains at 0%. Her objectives appear to be appropriate." It was not evident that team members were using data collected to drive planning in regards to necessary supports. This was particularly true in regards to risk discussions. Data that should have been reviewed by the team included test/laboratory results, skill acquisition goal data, injury and incident data, data related to nursing care plans (weight, number of seizures, hospitalizations, etc.), behavioral data, and response to medications. See section I for additional comments regarding adequately identifying risks. 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 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.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that	This provision item 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	Noncompliance

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	goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	services as well as section G regarding the coordination and integration of clinical services. As noted in F1b and F1c, representation from all relevant disciplines was not evident during planning meetings and adequate assessments were not completed prior to the annual meetings. IDTs will need to work together to develop ISPs that coordinate all services and supports. The facility did not have a process to ensure coordination of all components of the ISP.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of individual records was reviewed in various homes at the facility. Current ISPs were not available in two of 21 (10%) of the records. Although this was a sizeable improvement from the last monitoring visit, plans need to be available to staff providing supports. As noted in F1d, ISPs did not always include staff instructions for support that were clear enough for DSPs to follow. Staff interviewed by the monitoring team were not consistently familiar with PBSPs, PNMPs, healthcare plans, and risk action plans. Some staff interviewed could not describe risks and interventions needed by individuals that they were assigned to support. While staff could generally describe behavioral interventions, many staff were not able to relay healthcare risks or supports. As noted in F1c, it was not clear as to what supports should be provided for an individual during the course of a 24-hour day. Lack of integration of plans contributed to this confusion. Many separate plans existed that were not integrated into the one comprehensive plan. As the state continues to provide technical assistance in ISP development, a strong focus needs to be placed on ensuring that plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation.	Noncompliance
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	A review of records indicated that the IDT routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues, however, it was not evident that teams were aggressively addressing regression, lack of progress, and risk factors by implementing appropriate protections and supports, and revising plans as necessary. QDDPs completed monthly reviews. The monthly reviews did not support that data were reviewed monthly or that plans were modified when progress was not being made. For	Noncompliance

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	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.	example, the monthly reviews for Individual #431 for November 2011, December 2011, and January 2012 indicated ND (no data) for each outcome reviewed. The necessary action step for each outcome stated "continue." In February 2012, the monthly review noted 0% on four vocational outcomes. There were no comments on the lack of progress. Again, the necessary action was marked "continue." The review dated 10/3/11 for Individual #178 indicated that he had a sleep study for apnea on 9/2/11. Monthly and quarterly 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 ISPs 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 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	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 ISP document. • A review of training transcripts for 24 employees indicated that 24 (100%) had completed the new training on ISP process entitled Supporting Visions. As evidenced by findings throughout this report, training on the implementation of plans was not ensuring that plans were being implemented as written. The facility was aware of deficits in the implementation of the ISP and was providing additional training to direct support staff. The facility's self-assessment indicated that documentation regarding training of direct support staff on ISPs was not being captured, therefore, data were not available to review. The facility self-rated the provision as being out of compliance with this requirement. The monitoring team agreed with that assessment.	Noncompliance

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	updated competency- based training when the plans are revised.		
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 ISPs in the sample reviewed, all (100%) had been developed within the past 365 days. The facility self-assessment showed a noncompliance rating based on the fact that not all plans were available to staff. As noted in F2c, a sample of 21 plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. It was found that 10% of the plans in the sample were not current. As noted in F2d and other areas of this report, plans were not always revised when supports were no longer effective or applicable. 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.	The facility had tools to monitor requirements of section F including: • Individual Support Plan Monitoring Checklist • Section F Monitoring Tool • Monthly Review Monitoring Form • Peer Review of Individual Support Plan Quality enhancement activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility had made significant progress in this area. They had just begun to analyze findings and develop corrective action plans.	Noncompliance

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. It will be important for the QDDPs to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to address all risk that teams identify (F1a).

3. When individuals are not present for meetings, the QDDP should document attempts made to include the individual or LAR and how input was gathered to contribute to planning if the individual did not attend the meeting. When individuals consistently refuse to attend meetings, the

team should look at what factors contribute to the refusal to attend and brainstorm ways to encourage participation (F1b).

4. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT 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 ISPs. All supports and services should be integrated into one comprehensive plan (F1d).

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

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

8. IDTs 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).

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

10. Meaningful supports and services should be put into place to encourage individuals to try new things in the community. The IDTs should develop action steps that will facilitate community participation while learning skills needed in the community (F2a1).

11. Teams should develop meaningful, measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. Specific behavioral indicators should be identified to determine successful attempts at outcomes (F2a2)

12. IDTs 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).

13. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. The ISP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in ISPs (F2a4, F2c).

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

15. 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).

16. Ensure plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation (F2c).

17. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues (F2d).

18. Develop a process to revise ISPs when there is lack of progress towards ISP outcomes or when outcomes are completed or no longer appropriate outside of schedule quarterly review meetings. Review and revise plans when there has been regression or a change in status that would necessitate a change in supports. Ensure that staff are retrained on providing supports when plans are revised (F2d, F2e, F2f).

19. Develop an effective quality assurance system for monitoring ISPs (F2g).

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 Draft Policy: G- Minimum and Integrated Clinical Care o MSSSLC Section G Self-Assessment o MSSLC Section G Action Plan o MSSSLC Sections G and H Presentation Books o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily Clinical Services Meeting Notes Interviews and Meetings Held: o Dolores Erfe, MD, Medical Director o Angela Johnson, RN, Medical Compliance Nurse 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 Psychiatry Clinics o Daily Clinical Services Meetings
	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions. For the self-assessment, the facility described for each of the two provision items, a series of activities engaged in to conduct the self -assessment, the results of the self-assessment and a self-rating. During the week of the onsite review, the monitoring team met with the medical director and medical compliance nurse to discuss the self-assessment and this provision. Provision item G2 was rather direct, both in assessment and intent of the provision. Assessment of Provision G1 will require additional work. In moving forward, the monitoring team recommends that the medical director follow guidance from state office provided in the form of policy issuance or otherwise. Moreover, the medical director should review, for each provision item in this report, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive

	the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in noncompliance with both provision items. The monitoring team agrees with the facility's self rating.
	Summary of Monitor's Assessment: The facility continued to make progress in this area. Several steps occurred, locally and at the state level, in an effort to integrate clinical services. State office developed a draft procedure Minimum and Integrated Clinical Services to address the requirements of Provision G and Provision H. The final version of that policy had not been issued. The facility also drafted a similar policy. The monitoring team had the opportunity to meet with the medical director, and medical compliance nurse to discuss integration activities at the facility. It was clear that this important provision was taken seriously and, since the last onsite review, more thought and work had been done. It was also apparent that much work remained and the medical director needed assistance, guidance, and support from the facility director because many actions needed to occur in areas and disciplines that were not under her purview. Throughout the week of the review, the monitoring team encountered several good examples of integrated clinical services. Areas where integration was needed, but failed to be evident, were also noted. Continued work in this area is needed. The monitoring team expects that as additional guidance is provided from state office in the form of a finalized policy, the facility will have greater clarity on how to proceed.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	MSSLC made some gains in this area, but the monitoring team expected to see more progress. The lack of progress may have been due, in part, to the fact that this provision crossed numerous clinical disciplines and required many collaborative efforts. While it may appear to be a simple matter of fact that services should be delivered in an integrated manner, it actually takes thought and planning to achieve this outcome. The medical director explained that a facility policy was written and sent to state office for review. The policy mirrored state policy, but also included a synopsis of each clinical discipline and the services it provided. It did not clearly describe how the discipline worked to achieve integration with other disciplines. For example, the policy could have described, under the psychiatry section, those activities that psychiatry engaged in to promote integration with psychology, neurology, medical, pharmacy, etc., but it did not.	Noncompliance

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		It also did not outline how psychology integrated with speech and language pathologists or how nursing and psychology integrated. Nonetheless, it appeared that the facility had taken several steps in order to move towards substantial compliance. In addition to the discussion that was held with the medical director and compliance nurse, the monitoring team reviewed local and state procedures, conducted interviews, completed observations of activities, and reviewed records and data to determine compliance with this provision item. During the conduct of this review, many examples of integration of clinical services were observed. There were also several instances in which integration needed to occur, but did not. The following are examples of integration that were noted: • Daily Clinical Services Meeting - The monitoring team attended several meetings and found this to be a good effort at integration. This was a very large meeting and it usually lasted 15 -30 minutes. The medical director facilitated the meeting and participants included all PCPs, psychiatrists, chief nursing executive, pharmacy director, and psychology director. Reports included the medical staff on call report, and the 24-hour nursing and the psychology on call reports. The meeting did not actually produce minutes with actions responsible parties and due dates. • There were efforts to integrate some of the medical disciplines. For example, the medical staff discussed clinical interventions and physician orders with the clinical pharmacists each month. • There were numerous medical meetings designed to foster integration including the Medical Review Committee, the Polypharmacy Committee, and the Infection Control Committee. • The monitoring team observed during psychiatry clinic that there was some integration among nursing, psychiatry, psychology, and pharmacy with regard to the IDT process. • Collaboration between dental and habilitation resulted in several individuals receiving suction toothbrushing treatment. • There were a number of opportunities at MSSLC for nurses to participate in activities that promoted the integration of clinical services and ensured that individuals received the clinical services they needed. For example, daily campus-wide clinical meetings and weekly unit-based Focus meetings were held, and nurses, from nursing leadership to direct care nurses, were encouraged to attend and participate in the interdisciplinary reviews of individuals with emergent health and behavioral needs. • There was also a newly established "Active Treatment Monitoring Team," which included representatives from the facility's clinical services departments and included the Nursing Department. This team conducted daily rounds on the	

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		units during the evening shift. They interviewed home charges, direct care staff members, and individuals and they monitored the implementation of PNMPs, PBSPs, infection control procedures, and attention to health issues. During the shift, the team met to review their findings and outcomes of the strategies they implemented to ensure that individuals received the clinical services planned and developed to meet their needs. • PNMT members attended IDT ISPAs post-hospitalization and when there were other changes in status of individuals they were reviewing. Several areas offered great opportunities for improvement: • While information about various topics (e.g., polypharmacy, individuals with intractable epilepsy) were discussed with the necessary disciplines, it was not possible to determine the integration of that information into a relevant treatment plan for the individual. A meeting to briefly review and collate that information into an applicable plan of action for the individual was necessary. • There was a lack of integration of psychology and psychiatry. • The facility began conducting an onsite neurology clinic in February 2012. The neurologist saw individuals who had a seizure disorder and a psychiatric diagnosis. The psychiatrist did not attend neurology clinic. At the end of the day, some of the medical staff met with the neurologist to discuss the cases. While there was psychiatric participation in this meeting, the psychiatrist of record may not have been present to discuss their cases. This format would not result in integration of psychiatry and neurology. • The medical director described a process for pretreatment sedation that included discussion of medication selection at the Medical Review Committee meeting. This was also reported by the dental clinic staff. The monitoring team did not observe this. The medical director also reported that the policy for pretreatment sedation had not been completed. • The Pharmacy and Therapeutics Committee offered an opportunity for a rich discussion of many important clinical topics between multiple clinical disciplines. The discussions were limited to a quick reading of information. • The Medical Review Committee appeared to have some very good discussion about individuals who had been hospitalized with pneumonia, but the group failed to take advantage of the good information that they were generating. Including respiratory, habilitation, and nutrition services in the discussion of individuals with a history of aspiration and aspiration pneumonia could have possible elevated a good clinical discussion to a great one that resulted in new ideas and interventions that had the potential to alter outcomes. • There appeared to be a lack of integration of clinical services in terms of development of strategies and interventions to assist individuals who refused	

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		dental services. As discussed in section Q, ISPAs repeatedly failed to document any compelling evidence that teams completed appropriate assessments, implemented plans, and followed up on the success of those plans. • More improvement was necessary in the integration of psychology and master teachers and around SPO development, between rehab department and master teachers around communication SPOs, and between psychology and medical around noncompliance/desensitization plans. • It appeared that there was a reliance on an expected doctor's order for PNMT involvement when in fact any team member can make a referral and a physician's order would not be necessary. • The PNMT did not include IDT members throughout the process of assessment and review at this time, but rather presented findings after the assessment process was complete.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The current state medical quality audit included two questions that focused on Provision G2. Question #27 addressed the documentation in the IPN within five days by the physician. Question #28 addressed the physician's documentation of a rationale in those cases that the recommendation was not accepted. The medical staff were keenly aware of the requirements for this provision item. The self-assessment reported that for the months of September2011 through December 2011, 100% of consults were documented in the IPN. The external medical quality audit conducted in March 2012 showed a compliance rate of approximately 95% for Question #27. Question #28 was excluded. Combined data compiled by the monitoring team showed 84% compliance with documentation in the IPN and 81% compliance with timeliness (within 5 days). This is discussed further in Section L1. The facility required that consults be forwarded to the IDT for review. The facility scored low marks in this area. While nearly all consults reach the facility, on average, 54% of consults reached the units during the months of September 2011 through December 2011. In response to this, the medical and nursing departments met and developed a plan of correction. A new system of delivering the consults and records to the physicians was developed. Additionally, a new form was created that required the physician to indicate agreement or disagreement with the recommendations. This form would be forwarded to the RN manager who was responsible for presenting the form and the consult at the unite meeting for discussion. This process appeared cumbersome and required duplication of efforts by the physician, but the medical director believed it was necessary. It had not been implemented at the time of this review. Based on the facility's low	Noncompliance

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		compliance with forwarding consults to the IDT for review, this provision item was rated as being in noncompliance.	

Recommendations:

1. The medical director will need additional support if she is to continue in the lead role for this provision item (G1).

2. Consideration should be given to including in any local policy a requirement that all clinical departments develop a statement of their integration philosophy, describing how the department approaches integration with other key clinical areas (G1).

3. The facility needs to develop a system to assess if integration of clinical services is actually occurring. This will require creating measurable actions and outcomes (G1).

4. The facility needs a mechanism to track all consultations and appointments for diagnostics. Consideration should be given to using a format that will allow sorting by multiple fields including specialty, individual, appointment date, and PCP (G2).

5. State Office will need to address the use of the current external audit criteria (questions 27 and 28) as an assessment for compliance with Provision G2 (G2).

6. DADS should develop and implement policy for Provisions G1 and G2 (G1, G2).

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 Draft Policy: G- Minimum and Integrated Clinical Care o MSSSLC Section G Self-Assessment o MSSLC Section G Action Plan o MSSSLC Sections G and H Presentation Books o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily Clinical Services Meeting Notes Interviews and Meetings Held: o Dolores Erfe, MD, Medical Director o Angela Johnson, RN, Medical Compliance Nurse 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 Psychiatry Clinics o Daily Clinical Services Meetings
	Facility Self-Assessment: The facility submitted its self -assessment, an action plan, and a list of completed actions. For the self-assessment, the facility described for each of the seven provision items, a series of activities engaged in to conduct the self -assessment, the results of the self-assessment, and a self-rating. During the week of the onsite review, the monitoring team met with the medical director and medical compliance nurse to discuss the self-assessment and the provision. In moving forward, the monitoring team recommends that the medical director follow guidance from state office provided in the form of policy issuance or otherwise. Moreover, the medical director should review, for each provision item in this report, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews,

	data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in noncompliance with all seven provision items. The monitoring team agrees with the facility's self rating.
	Summary of Monitor's Assessment: The facility updated the self-assessment on 3/14/12 and it focused entirely on the medical department. It appeared that, after that date, some additional work was done to pull together some data from other areas for inclusion in the presentation book. Again, almost every item related to the medical or psychiatric departments. The presentation book contained a few documents which appeared to have been put together quickly. There were physician document tracking logs with strikethroughs and data blacked out. In general, it gave the sense that not enough care was given to this provision and indeed that was the case. The monitoring team was told that the presentation book would include data on assessments, but it did not. Overall, the monitoring team was disappointed because more could have been and should have been accomplished over the past six months. There were, however, some positive findings. Routine assessments, such as annual medical assessments were being completed in a timely manner, but in most other areas, serious deficiencies were identified. Clinical protocols had been implemented, thereby, laying the groundwork to assess the efficacy of some treatments. Again, there was no evidence presented on what, if anything was occurring in other areas related to this provision item. During the September 2011 visit, the monitoring team commented that little progress had occurred. Based on the overall vastness of what needed to occur, only small gains were noted.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The state office policy, which remained in draft, required each department have procedures for performing and documenting assessments and evaluations. Furthermore, assessments were to be completed on a scheduled basis, in response to changes in the individual's status, and in accordance with commonly accepted standards of practice. Limited progress was made in this area. The monitoring team was informed that compliance data for the various assessments were included in the presentation books. The AMA tracking log could not actually be used because it did not provide the previous assessment date which is what was needed to determine the actual compliance with timely completion of the annual assessment. Compliance data were available from the section L record sample. No composite data were given for quarterly summaries.	Noncompliance

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		Another document was included that stated 705 nursing quarterly and annuals due; 222 were delinquent from September 2011 to February 2012 (31%). Another document stated that, according to Habitation Director Brandie Howell, all assessments were current. While each department may have monitored its assessments, it did not appear that there was any central place where these data were housed and monitored. Moreover, the comments were limited to timelines. This report contains, in the various sections, information on the required assessments. This provision item essentially addresses the facility's overall management of all assessments. In order to determine compliance with this provision item, the monitoring team participated in interviews, completed record audits, reviewed assessments and facility data. The results of those activities is summarized here: • The external medical quality audits noted compliance rates of approximately 100% for Round 4 and 100% for Round 5. The monitoring team found compliance an overall compliance rate of 96%. The monitoring team would like to emphasize that compliance must be based on an annual assessment being completed within 365 days of the previous assessment. The medical quality audits monitor additional quality components for the annual medical assessments. The facility will need to include those in the self-assessment as well. This provision item assesses the timeliness and quality of assessments. Section L provides additional information on the annual and other medical assessments • Quarterly Drug Regimen Reviews appeared to have been completed in a timely manner, but timely completion was negated due to a delay in getting the evaluations to the medical staff. • Annual Dental Assessments were found in all records reviewed. Data submitted showed compliance was consistently over 85%. • Due to transition in the support staff of the psychiatry clinic and other changes, such as the resignation of three psychiatrists since last review, the data were not updated to determine if assessments (90-day evaluations) were conducted on a regular basis. • The facility completed 66% of comprehensive evaluations as described in the Appendix B format. Ninety-three individuals at MSSLC still required a comprehensive psychiatric assessment. • With regard to health status, the psychiatrist was not identifying the risks versus benefit of the psychotropic medication that impact other health conditions, in concert with the IDT. This was reflected in the inadequate consent process, polypharmacy regimen pervasively utilized at MSSLC, and insufficient	

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		documentation (e.g., BSP, 90-day reviews). This could be accomplished by expanding the IDT in psychiatry clinic to include the review of these factors. • The review of 25 individuals' records revealed that over one-third (nine) of the 25 individuals' records failed to have a current quarterly nursing assessment filed in their records. That is, nine individuals' most current quarterly nursing assessments were completed either on or before 12/15/11 and were two weeks or more past due. • There continued to be a pattern of failure by the nursing department to ensure that emergent changes in individuals' health status, risks, and needs were identified, assessed, and addressed in a timely manner, reported to physicians, and closely monitored and evaluated until resolution. There was also evidence of failure to ensure that ACPs were developed and implemented in a timely manner, and/or HMPs were reviewed and revised as significant changes occurred. • Initial psychological assessments, and annual psychological assessments were not consistently complete. Additionally functional assessments were not completed for all individuals with PBSPs. • Annual assessments and updates were completed consistently for those who received some level of support or service from OT, PT, or speech. The review of individuals post-hospitalization or for other changes in status was less consistent and documentation by these clinicians was limited in many of these cases. Provision H1 addressed the timeliness and adequacy of assessments, but the facility only noted timeliness and made no comment regarding the quality of any assessments. No training was provided related to ICD-9. The medical director indicated that physicians would receive ICD-10 training on April 2012. It should be noted that ICD 10 will not be implemented until the end of 2013. There appeared to be some confusion with this fact that none of the master bills were rejected.	
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	The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • Generally, the medical diagnoses were consistent with ICD nomenclature. • Over the course of the visit, the monitoring team observed the psychiatry team struggling with establishment of diagnostic criteria in an effort to appropriately diagnose individuals. Throughout the last several visits, there have been numerous changes in psychiatric staffing resulting in lack of consistent care for the individuals and thus inconclusive case formulations and diagnostics. • Additionally, records reviewed did not consistently reveal documentation of specific criteria congruent with the DSM IV TR terminology to justify assigned	Noncompliance

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	Classification of Diseases and Related Health Problems.	diagnostics • None of the 25 sample individuals' nursing assessments resulted in a complete, accurate list of their nursing needs, consistent with the fundamentals of NANDA, which were to ensure that all individuals' evidence-based nursing diagnoses were complete, accurate, and relevant to the individuals such that appropriate interventions would be developed and implemented and expected outcomes would be identified and achieved vis a vis comprehensive nursing care plans. No training was provided related to ICD-9. The medical director indicated that physicians would receive ICD-10 training in April 2012	
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.	The facility implemented the state issued protocols for a number of conditions, including seizure management, bowel management, aspiration, urinary tract infections, osteoporosis, and diabetes. Quality audits of diabetes, osteoporosis, and aspiration management were completed in March 2012. Based on the facility's own reviews, interventions were frequently not clinically appropriate as compliance with some process indicators was low. This is discussed in section L3. In order for the monitoring team to assess compliance with this provision item, the usual activities of interview and document reviews were completed. • Based on the review of records listed in section L, the medical staff generally responded to the needs of the individuals, providing treatments and ordering diagnostics. Improvement was needed in timeliness and appropriateness of laboratory follow-up and sometimes hospital follow-up. There was also a need to focus on certain high risk conditions such as aspiration. The facility will need to expand its clinical indicators now the clinical protocols are developed. Again, the facility must include all clinical disciplines when addressing this provision item.	Noncompliance
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	The facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines. Medical quality audits were completed, but the criteria used will need to be reviewed. Clinical indicators assess particular health processes and outcomes. Monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritization of health care delivery.	Noncompliance

#	Provision	Assessment of Status	Compliance
	a clinically justified manner.	The facility will need to give considerable thought to this process to ensure that a solid combination of clinical indicators is selected. This must be established for individuals and for facility aggregate data. The monitoring team again emphasizes that clinical indicators must be developed for all clinical areas. The current local draft policy addressed only medical indicators. Indicators are needed for psychiatry, psychology, and nursing, and habilitation services.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The facility did not have an overarching plan to address this provision item. Databases were established to track some elements of preventive care, and seizure management. The facility must address issues related to data management. This is discussed in section L. With the exception of the document requests, for the data elements that were in place within the medical department, there was no evidence that this information was reviewed and analyzed on a routine basis. There was no systematic monitoring of health status of all individuals. Achieving such a system will require collaboration among many disciplines due to the overlap between risk management, quality and the various clinical services. The first step in the process is to define what is important to the individuals and what is important that the facility monitor. Much of this work had already been completed. The facility needs to proceed with developing a comprehensive list of indicators based on these finings.	Noncompliance
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.	As mentioned in H5, the facility needs to establish a comprehensive set of clinical indicators. Many of those will be based on clinical guidelines developed. There are many other indicators that could and should be included. Examples would include the rate of hospitalizations, readmission rates, the incidence of pressure ulcers, the days of healing for pressure ulcers, the number of acute interventions required for bowel management, the prevalence of dehydration and the prevalence of undesired weight loss. Once the indicators are established and treatment expectations outlined, audits of records and other documents will indicate if treatments and interventions were appropriate.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical	State office had developed a draft policy for Provisions G and H. The facility had not finalized the local policy on minimum common elements. It should be reviewed and revised as necessary. The revision should include those steps listed in the action plan that addressed how the various departments will monitor assessments and other activities.	Noncompliance

#	Provision	Assessment of Status	Compliance
	services policies, procedures, and guidelines to implement the provisions of Section H.		

Recommendations:

1. The facility must ensure the following with regards to assessments:
    a. All assessments must occur within the required timelines. This will require tracking of scheduled assessments in all clinical disciplines.
    b. Interval assessments must occur in a timely manner and in response to a change in status.
    c. All assessments must meet an acceptable standard of practice (H1).

2. In addition to tracking assessments, the medical director will need to generate a report on a regular basis, perhaps quarterly, that shows compliance with timelines, appropriateness of assessments, the quality of assessments and other chosen indicators. If deficiencies are noted, a corrective action plan should be developed to address the problems. This should apply to all clinical disciplines (H1).

3. The medical director will need to ensure that the medical diagnoses are consistent with the signs and symptoms of the condition (H2).

4. The facility must develop a comprehensive list of clinical indicators across all clinical disciplines. The timeliness and clinical appropriateness of treatment interventions will be difficult to measure without establishing clinical indicators that assess (1) processes or what the provider did for the individual and how well it was done and (2) outcomes or the state of health that follow care (and may be affected by health care) (H3, H4).

5. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens (H6).

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 MSLLC Policy #44: At Risk Individuals dated 12/15/11 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 List of serious injuries for the past six months o List of individuals with the greatest number of injuries o List of individuals seen in the ER since 1/1/11 o List of individuals hospitalized since 1/1/11 o List of individual receiving enteral feedings. o List of individuals with pneumonia incidents in the past 12 months o List of individuals with choking incident since the last review o List of individuals at risk for aspiration o List of individuals at risk for respiratory issues o List of individuals at risk for contractures o List of individuals at risk for diabetes o List of individuals at risk for heat o List of individuals at risk for urinary tract infections o List of individuals at risk for dental 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 fluid imbalance o List of individuals at risk for falls o List of individuals at risk for infections o List of individuals at risk for fractures o List of individuals at risk for GI concerns 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 at risk for weight concerns o List of individuals with a pica diagnosis 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 Injuries since 9/1/11 o ISPs, Risk Rating Forms, Risk Action Plans for: • Individual #151, Individual #72, Individual #500, Individual #560, Individual #313, Individual #431, Individual #279, Individual #328, Individual #155, Individual #589, Individual #53, and Individual #518 <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs o Pat Samuels, Incident Management Coordinator o Charlotte Kimmel, PhD, Director of Psychology o Valerie McGuire, QDDP Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 3/27/12 and 3/29/12 o Human Rights Committee Meeting 3/27/12 o Shamrock PIT Meeting 3/28/12 o Restraint Reduction Committee Meeting 3/28/12 o 2nd Quarterly Review Meeting for Individual #477 o Annual ISP meeting for Individual #51 o Annual ISP meeting for Individual #120
	Facility Self-Assessment: MSSLC submitted its self-assessment. It was updated on 3/15/12. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using the tools developed by the state office to measure compliance with the Settlement Agreement. The self-assessment indicated that the findings from the facility's audit process were used to self-assess compliance. According to the self-assessment, the QDDP Educator had reviewed 100% of the At Risk Action Plans monthly and the QA department had reviewed 2% of all plans completed. The facility self-assessment commented on the overall compliance rating for each provision item, based on

	the sample of restraints audited. • The facility rated I1 as being in substantial compliance based on completion of risk assessments for all individuals at the facility. The self-assessment did not comment on the accuracy of risk ratings. • I2 and I3 were rated as noncompliant. The self-assessment noted that data were incomplete to date. Additional details from audit findings were not noted. The facility was moving in the right direction with the new self-assessment process. It will be important to look at the self-assessment activities in more detail and determine if the audit process is an effective way to assess compliance. The facility assigned a rating of substantial compliance to provisions I1. The monitoring team did not agree that the facility was in substantial compliance with any of the three provisions of section I, although there had been progress made towards compliance in each area.
	Summary of Monitor's Assessment: Some positive steps MSSLC had taken towards compliance with this provision included: • All individuals at MSSLC had been assessed using the statewide risk assessment. • Enhanced guidelines were developed by the psychology department to more accurately rate behavioral risks. • Training was provided to IDTs on all residential units regarding the appropriate way to complete the new risk rating and action plan forms. • Teams discussed the aspiration pneumonia tool, coordinated with the integrated risk rating form. • Section I monitoring tools had been completed for all individuals • Twelve individuals had been referred to the PNMT. While significant progress had been made on meeting compliance through an initial attempt to ensure all individuals had been assessed and action plans were in place to address risks, the facility was not yet in compliance with the three provisions in Section I. Teams were still not accurately identifying risk factors. Teams could not adequately discuss risk factors without current, accurate assessments in place. Staff were not adequately trained on monitoring risk indicators and providing necessary supports. All staff needed to be aware of and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. The facility was still waiting on consultation and training on the new ISP and risk identification process from the state office. This training should move teams further towards integrating the risk process into the ISP development process.

#	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 IDTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the IDT 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 when appropriate. A list of indicators for each of 21 risk areas had been identified by the 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 had identified a target list of individuals at risk for aspiration. Eighteen individuals at the facility had been identified as high risk for aspiration and 79 were rated as medium risk. The list indicated that all individuals at high or medium risk for aspiration had a plan in place to address the risk. Individual #515 had been hospitalized three times in the past year for aspiration pneumonia, however, she did not appear on the list of individuals at risk for aspiration. Observation of annual IDT meetings scheduled the week of the review showed that IDTs were still working on how to integrate the new risk identification process with the ISP development process. Nurse case managers had recently been assigned responsibility for attending meetings and facilitating the risk discussion. Across the IDT meetings observed by the monitoring team, there was a range in the depth of discussion across these meetings as noted below and in section M5. Teams were beginning to address health indicators, but there was still a strong reliance on guidelines developed by the state that did not take into consideration integrated risk factors. Clinical indicators were not readily available at meetings and, therefore, not always considered when determining health risk ratings. 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 being used to identify risks. The monitoring team observed the 2nd quarterly IDT for Individual #477. This team held a very good discussion around his risk and how certain risk factors were interrelated. For example, the team acknowledged that her diagnosis of osteoporosis put her at high risk for falls and fractures. She was non-ambulatory due to a recent fall resulting in a fracture. The IDT identified that she now had an increased risk of skin breakdown. The annual IDT meeting for Individual #51 was also observed by the monitoring team. The QDDP led the risk discussion. Her team, however, did not consider her health history or clinical indicators when assigning risk ratings. Her mother was able to provide relevant historical information in regards her risk factors that impacted her risk ratings.	Noncompliance

#	Provision	Assessment of Status	Compliance
		For example, the team determined that she was not at risk for cardiac issues. Her mother asked that the team assign a medium risk because she had a history of weight gain, was taking Lipitor, and had a family history of cardiac disease. Similarly, the nurse stated that she was at low risk for diabetes. Her mother noted that her sugar level had been elevated in the past when she was on certain medications and she had a family history of diabetes. The team did not have data or health indicators necessary to thoroughly evaluate her risks. QDDPs need to ensure that all assessments are current and that health history and clinical data is accessible to IDT members at meetings. A sample of ISPs, assessments, and the facility risk rating list were reviewed to determine if risks were being consistently identified and addressed by IDTs. The following are some examples where risks were not appropriately identified in documents reviewed or ratings conflicted with assessment information. ▪ Individual #72 had been hospitalized four times between 9/5/11 through 11/21/11. This included hospitalization for respiratory distress and aspiration pneumonia. He had many complex interrelated health care needs. The facility aspiration list indicated that he was rated as a medium risk for aspiration. He should have been considered high risk for aspiration and an aggressive plan to address aspiration should have been implemented. ▪ Individual #500's risk assessment indicated that he was at low risk for constipation, gastrointestinal problems, and aspiration. His OT/PT assessment recommended a mealtime plan to address problems with reflux. His nursing assessment indicated that he had a diagnosis of GERD, took medication for constipation and reflux, had health care plans in place to address constipation and GERD, and was at high risk for aspiration. ▪ Information in Individual #560's ISP, nutritional assessment, risk assessment, and monthly reviews conflicted regarding his risk for weight loss. His ISP indicated that he was at medium risk for weight loss. He was estimated to be below his desirable weight range, though his BMI was noted to remain within standards. His risk assessment indicated that the team identified him at high risk for weight loss, though he was within his desirable weight range. Lab values were not reviewed for determination in either assessment. ▪ Individual #313's risk assessment indicated that he was at low risk in all areas. There were no clinical indicators included in the rationale section of the assessment to justify the ratings. His ISP indicated that he was at medium risk for challenging behaviors. ▪ Individual #151 was hospitalized four times in 2011 and was seen in the emergency room twice in the past six months. He had complex health issues. o His ISP dated 10/27/11 indicated that he was at high risk for aspiration, respiratory compromise, GI problems, osteoporosis, fractures, and urinary tract infections and was at medium risk for dental health,	

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		constipation, cardiac disease, fluid imbalance, weight, and falls. o His dental assessment indicated that his periodontal disease placed him at higher risk for aspiration. The team did not adequately consider his interrelated health issues when assigning risk ratings. o Similarly, he should have been rated high risk for skin integrity since he relied on staff assistance for mobility and repositioning. o His ISP noted that he had action plans in place to address high and medium risk areas, but there was no summary of the plan included in his ISP. A copy of his ISP was requested by the monitoring team. The document received did not include his risk action plan, indicating that it was not considered a part of the ISP. The ISP should be a comprehensive document detailing all supports and services to be provided by staff. Additional examples are listed at the end of section M5 and in section O2. For both short and long range planning, the teams will need to: • Frequently gather and analyze data regarding health indicators (e.g., changes in medication, results from lab work, engagement levels, mobility) . • Discuss the interrelatedness of risk factors in an interdisciplinary fashion. • Focus on long term health issues and be more proactive in addressing risk through action plans to monitor for conditions before they become critical. • 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. • Monitor progress towards outcomes and share information with all team members so that plans can be revised if progress is not being made or regression occurs. The facility's self-assessment indicated that the facility had given itself a substantial compliance rating for this provision based on completion of risk assessments for all individuals. The self-assessment did not comment on the adequacy of assessments. The facility needs to ensure that present risk assignments are reviewed for accuracy.	
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	The At Risk policy required that when an individual was identified at high risk, or if referred by the IDT, the PNMT or BSC was to begin an assessment within five working days if applicable to the risk category. The PNMT or BSC was required to assess, analyze results, and propose a plan for presentation to the IDT within 14 working days of the completion of the plan, or sooner if indicated by risk status. As noted throughout this report, it was still not evident that all risks were appropriately	Noncompliance

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	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.	identified by the IDT. The facility will have to have a system in place to accurately identify risks before achieving substantial compliance with I2. In the sample reviewed, it was evident that teams were meeting to review risk levels, in at least some cases, when health status changed. For example, Individual #155 was hospitalized on 3/7/12 due to head injuries. His IDT met on 3/9/12 to review his risk levels and revise his risk action plan. The IDT determined that he was at greater risk for falls. It was not evident that the team had requested an updated PNMT assessment to develop a plan to address his increased risk. One of the most important aspects of a health risk assessment process is that it effectively prevents the preventable and reduces the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. The facility was not yet in compliance with this provision item.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the IDT. It required that the IDT implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. A majority of the ISPs that were reviewed included general strategies to address identified risks, but again, not all risks were identified as a risk for each individual. The new policy required that the follow-up, monitoring frequency, clinical indicators, and responsible staff will be established by the IDT in response to risk categories identified by the team. According to data provided to the monitoring team, a plan was in place to address all risks for those individuals designated as high risk or medium risk in any area. However, as noted in I1, accurate risk ratings were not necessarily being assigned, so adequate plans were not in place for all individuals. None of the plans in the sample included clinical indicators to be monitored to accurately determine the adequacy of the plan for all action steps. For example, the Risk Action Plan for Individual #328 had numerous action steps to address his high risk status for aspiration, osteoporosis, skin integrity, polypharmacy, and fractures. The plan included how frequently each action step would be monitored, however, did not include clinical indicators to be monitored for any of the action steps. The risk action plan and ISP did not include enough detail to offer DSPs guidance in providing adequate support. For example, both noted that a tilt in space wheelchair for positioning was used to address skin breakdown. There was no guidance on when he should be in the chair or how often	Noncompliance

#	Provision	Assessment of Status	Compliance
		he would be repositioned. One of the action steps to address osteoporosis stated "be gentle when providing physical assistance." There was no guidance in the action plan for how staff should reposition, transfer, or otherwise provide necessary supports. Additionally, plans were not adequately integrated into ISPs. For example, • Individual #431's ISP indicated that he was at high risk for choking and aspiration. He had two choking incidents in the past year. His risk action plan was not integrated into his ISP outcomes or attached to the ISP for reference. • Individual #279's risk assessment indicated he was at medium risk for cardiac concerns. His ISP stated that he was at low risk for cardiac concerns. There was no mention of how staff should monitor his risk in his ISP. It will be necessary for the facility to have a system in place that accurately identifies risk prior to achieving substantial compliance with I3 requirements. As noted throughout this report, intervention plans often did not provide enough information for direct support staff to consistently implement support or were not carried out as written, therefore, individuals remained at risk. See additional comments throughout this report regarding the monitoring of healthcare risks. The facility self-assessment indicated that the facility was not in compliance with this provision. The monitoring team agrees with that assessment.	

Recommendations:

1. Ensure assessments are completed prior to annual IDT meetings and results are available for team members to review (I1).
2. Ensure that risk rating accurately reflect risks identified through the assessment process (I1).
3. All health issues should be addressed in ISPs 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 IDTs 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 ISPs and other plans readily available at all times to provide necessary supports to each individual in the home (I2 and I3).
7. 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 (I1 and I2).

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 IST 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 ISP 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 inservice training for facility nursing staff regarding administration of MOSES and DISCUS examinations o Ten examples of MOSES and DISCUS examinations 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; trazodone; 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; ISP, and ISP 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 IDT, ISP, ISPA, 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 had 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 inservice 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 ISP, ISPA, BSP, or IDT 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, 3/29/12 o All data presented, doctor's orders, and Dr. Kirby's documentation for psychiatry clinic, 3/27/12 regarding Individual #161, and Individual #293 o All data presented, doctor's orders, and Dr. Vega's documentation for psychiatry clinic 3/28/12 regarding Individual #49, Individual #356, Individual #40, and Individual #32 o Documents for scan call conducted by Kendall P. Brown, M.D. regarding Individual #350 o These following documents for all of the individuals listed in the above four bullets and for Individual #560, Individual #510, Individual #331, Individual #303, Individual #16, Individual #127, Individual #539, Individual #42, Individual #109, and Individual #356 • Identifying data sheet • Social History (most current) • 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) including Appendix B evaluation • Neurology section (for the past year) • Nursing Assessment and Nursing Report for Psychiatry Clinic • Psychology Evaluation (Most recent) and psychology report for psychiatry clinic • MOSES/DISCUS results (for the last six months) • Reiss Screen • Pharmacy section (for the last six months) • Consent section (for psychotropic medication and pretreatment sedation) • Integrated progress notes (for the last six months) • ISP and ISP addendums/reviews/annual (for the last six months)

	• Behavior Support Plan • Desensitization Plan Interviews and Meetings Held: 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 Anyssa Garza, Ph.D., Pharmacy Director o Group meeting with the lead psychiatrist (Kendall P. Brown, M.D.), Medical Director, psychiatric assistants (Ms. Bobbie Hall and Ms. Virginia Jackson), and the facility psychiatrists (Juanita Kirby, M.D. and Linese M. Vega, M.D.) o Ms. Iva Benson, State Office Field Operations Coordinator Observations Conducted: o Psychiatry clinic conducted by Juanita Kirby, M.D. o Psychiatry clinic conducted by Linese M. Vega, M.D. o Psychiatry clinic and scan call conducted by Kendall P. Brown, M.D. o Behavior Therapy Committee (BTC) meeting o Clinical Services meeting o Pharmacy and Therapeutics (P&T) Committee Meeting o Physicians' working lunch o Medical Review Committee meeting o ISP for Individual #127 o Polypharmacy Meeting o Scan call between the Scott & White Hospital Neurologist and MSSLC medical staff
	Facility Self-Assessment: MSSLC submitted two separate documents regarding section J for the self-assessment (dated 2/21/12 and 3/13/12), previously called the POI. For the first document, the self-assessment, the facility was instructed to provide the activities engaged in to conduct the review of a particular provision item, the results and findings from these activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility assigned a lead psychiatrist since the last review who provided the update for section J to the monitoring team. The facility self-assessment indicated what activities the facility engaged in to conduct the review, but the activities selected by the facility were not always pertinent to the content of this provision. Further, the activities the facility engaged in were not consistent with what the monitoring team outlined for the particular provision. For example, in J1 (each SSLC shall provide psychiatric services only by persons who are qualified professionals), the facility noted that activities engaged in to conduct the self-assessment consisted of "record reviews of licensed psychiatric clinical staff." Record reviews were not pertinent to the J1. The monitoring team did not understand the term "licensed" in regards to psychiatric staff. The facility

	should have focused on information, such as board certification, experience in regards to working with individuals with developmental disabilities, and specialization in child and adolescent psychiatry (outlined in the psychiatrist's curriculum vitae and confirmed upon interview of the psychiatric staff). In the comments section of each item of the provision, there was a summary of the results of the self-assessment and the self-rating. The self-assessment listed the action plans for each provision of the Settlement Agreement. In addition, during the onsite review, the monitoring team reviewed the presentation book for the overview of the facility progression. The lead psychiatrist self-rated the facility as being in substantial compliance for only one provision item (J1). The monitoring team agreed with the self-rating provided by the facility and rated substantial compliance for only provision J1. The monitoring team's review was based on observation, staff interview, and document review. In discussions with the lead psychiatrist, medical director, director of psychology, and the facility psychiatrists, the need for improved integration was noted. Most provision items in this section rely on collaboration with other disciplines. The second document, detailing the action steps, 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). 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 would benefit from the eventual development of a self-monitoring tool that mirrors the content of the monitoring team's review for each provision item of section J as outlined in the monitoring report (i.e., topics that the monitoring team commented upon, suggestions, and recommendations made within the narrative and/or at the end of the section). For example, the monitoring team report focuses on the completion of the comprehensive psychiatric evaluations in J6. The facility should also capture the pertinent review and provide data of the completion of Appendix B evaluations in J6 (each SSLC shall develop…psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B). The facility utilized a monitoring tool that did not match the content of the monitoring team's report. For example, the facility focused on Appendix B findings in J2 and in J6. The monitoring team encouraged the facility staff to refer to the monitoring team's report to design the activities and review of a particular provision item consistent with the monitoring team.

	Summary of Monitor's Assessment: MSSLC was found to be in substantial compliance with the first provision item: providing psychiatric services by persons who were qualified professionals. The facility, however, continued to experience difficulty with the retention of psychiatrists. A lead psychiatrist was designated since the last visit. In discussions with the lead psychiatrist, medical director, director of psychology, and the facility psychiatrists, the need for improved integration was noted. Most provision items in this section rely on collaboration with other disciplines. There was an overreliance on psychotropic medications, a paucity of non-pharmacologic interventions, and use of multi-agent chemical restraints. The different departments must communicate with one another to allow for appropriate assessment and intervention to take place by the IDT. The evaluation, case formulation, diagnosis, and justification for treatment with medication remained insufficient facility-wide. The adequate completion of psychiatric assessments, both quarterly and Appendix B comprehensive evaluations, were likely hampered by a lack of consistent and insufficient number of psychiatric resources. The dental, medical, psychiatry, and psychology department staff provided data regarding pretreatment sedation that were not done in a way that showed an integrative review. Effort must be made with respect to the development of individualized treatments or strategies and/or desensitization protocols. The monitoring team experienced difficulty with determination of which individuals were referred following a routine Reiss screen, individuals screened due to a change in status or circumstance and then entered the clinic, or individuals who were previously enrolled in the psychiatry clinic. 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. 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 monitoring team was provided the number of individuals classified as receiving a polypharmacy regimen, yet no one knew how many individuals were actually prescribed psychotropic medication at MSSLC when the polypharmacy committee met. Facility-level data must include the overall information of how many individuals were prescribed psychotropics, and of these individuals, who received intra-class and/or interclass polypharmacy. The prescriber must justify the clinical hypothesis guiding said treatment. This justification must then be reviewed at a facility level review meeting.

	It was good to see that the nursing staff had designed the database to track the administration of the MOSES and DISCUS. Psychiatry must utilize this information and work together with nursing to make this process clinically applicable. 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. On a positive note, there was the initiation of onsite neurology clinics at MSSLC. The psychiatrist, however, was available to speak with the neurologist at the end of the consultation. Unfortunately, this defeated the whole purpose of the neurologist and the psychiatrist coordinating the use of medications when they were prescribed to treat both seizures and a mental health disorder. There remained the lack of identification of target symptoms for AED regimen.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications</u> 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, provides consulting psychiatric services for MSSLC via phone. Dr. Kendrick was present via a scan call at MSSLC for this site visit. The monitoring team informed the facility 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 sometimes occur onsite at the facility and/or via telemedicine consultation as opposed to all contact being performed by phone. All three of the psychiatrists providing services at the facility were either board certified or board eligible in adult psychiatry by the American Board of Psychiatry and Neurology. This information was obtained per interview by the monitoring team because the detail of board status has not been consistently listed in the psychiatrist's vitae. This provision requires the facility to provide psychiatric services only by persons who are qualified professionals therefore this information should be documented. <u>Experience</u> The lead psychiatrist, Kendall P. Brown, M.D., was board certified in adult and geriatric psychiatry by the American Board of Psychiatry and Neurology. In regards to prior experience treating individuals with developmental disability, Dr. Brown noted that he	Substantial Compliance

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		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 Bexar and Dallas County. Dr. Brown was the only remaining psychiatric staff since the last monitoring review at MSSLC. Dr. Vega had limited experience working with individuals with developmental disabilities. She was temporarily assigned to MSSLC as she was departing to further her studies in a child and adolescent residency program. Dr. Kirby had numerous years of experience in the field of psychiatry and previously provided care for some individuals with developmental disabilities in her practice. Dr. Kirby served in a directorship capacity for the Dallas County Mental Health and Mental Retardation division. <u>Monitoring Team's Compliance Rating</u> Based on the qualifications of the psychiatrists, this item was rated as being in substantial compliance. Psychiatry staffing, administrative support, and the determination of required FTEs are addressed below in section J5.	
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.	<u>Number of Individuals Evaluated</u> At MSSLC, 274 of the 390 individuals (70%) received psychopharmacologic intervention at the time of this onsite review. Since last visit, an additional 15 individuals had been prescribed psychotropic medication. As part of the psychiatry department's data management, the reason of the increase in prescription of psychotropic medication should be analyzed and described (e.g., due to new admissions of individuals who are taking medication). Facility-level data must also include how many individuals were prescribed psychotropics. The monitoring team encouraged the facility to keep track of reasons of the increase in prescription of psychotropic medication in a detailed fashion and to submit this to the facility's QA program. Per interviews with the new two full time psychiatric assistants that coordinated the psychiatrists' schedule, individuals were to be seen in clinic a minimum of once per quarter for their quarterly medication review. There were concerns regarding the consistency of psychiatric staffing due to the resignation of three psychiatrists since last review (see J5 below). The limited and constantly changing psychiatric staff was one of the factors resulting in the lack of knowledge regarding the individual's case history and contributed to inadequate revision of diagnostics. <u>Tracking Diagnoses and Updates</u> Due to the assignment of two new psychiatric assistants and lack of an appropriate	Noncompliance

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		transition phase, the data regarding diagnostics and updates were not available to the monitoring team. Tracking of individuals enrolled in clinic was not being consistently maintained. The monitoring team requested this pertinent information, and was informed that it would be presented next visit. The medical director said that the psychiatric assistants would be required to update this tracking at least monthly. The facility did not have an organized system to manage and track diagnoses and diagnostic updates (this was also an issue at the last onsite review). The psychiatric assistants maintained a database to track these elements, yet oftentimes, the database was not updated in a timely manner and the individual's record did not match the current diagnoses assigned by the psychiatrist and IDT. <u>Evaluation and Diagnosis Procedures</u> Upon observation of several psychiatry clinics during the monitoring review, it was apparent that the team members attending the visit were well meaning and interested in the treatment of the individual. There was also open discussion by the psychiatrist during the clinic informing the monitoring team about how problematic it was to complete the necessary forms and documentation. The forms were designed for completion via handwritten notation. The handwritten notes were frequently not legible. It would be better to design a system of typed documentation, updated during the quarterly evaluation, or as clinically indicated, as opposed to each psychiatrist handwriting all of the information numerous times. Although there was effort placed into the improvement of the clinic process regarding psychiatric documentation, the monitoring team had difficulty determining the current diagnoses due to discrepancy in psychiatric diagnoses across different disciplines' evaluations (e.g., physician's annual medical review, ISP, PBSP). Due to the facility not having an updated database to track these elements, the IDT and monitoring team were not able to determine details of diagnostics or revision of diagnostics. The following comments were from a review of the record of Individual #109 and exemplify typical problems with the process used for evaluation and diagnosis. The Quarterly Psychiatric Medication Review Worksheet provided by psychology and signed 12/20/12, noted target symptoms of "aggression to others, inappropriate verbal behavior, and unauthorized departures of the area." There were, however, no target symptoms regarding psychosis or mood listed for this minor with an Axis I diagnoses of Schizoaffective Disorder (in addition to other diagnoses) that was prescribed intra-class polypharmacy. The evaluation did not take place in a clinically justifiable manner. There was lack of an entire review of medications for this individual who also received additional medications, such as AED for a seizure disorder, in addition to the intra-class	

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		polypharmacy of two neuroleptics, that could contribute to lowering of the seizure threshold, and lack of review of drug-drug interactions. The form only outlined "Current Psychotropic Medication." The Quarterly Psychotropic Medication Review dated 9/27/11 was not complete because there was nothing noted about the justification of polypharmacy. The signature of the psychiatrist was not legible. The Quarterly Drug Regimen Reviews addressed the medication regimen, monitoring and drug effectiveness, and comments that should have been utilized in this clinic setting. Further, the QDRR dated 9/29/11 noted this individual was not free of potential interactions and there was lack of appropriate monitoring and evaluation of drug effectiveness. The IDT should access such valuable information during the psychiatric clinic setting. <u>Clinical Justification</u> A review of a sample of 17 records revealed varying quality in documentation for the psychiatric reviews. Although the Quarterly Psychotropic Medication Review Form was a good attempt by the facility to streamline the documentation, it led to some unintended problems, such as leaving out pertinent diagnostic and medication information, that impacted attention to clinical care. The documentation in the QPMR did not correspond with DSM-IV-TR criteria and did not support diagnostics assigned. If diagnostics were not appropriately addressed in a clinically justifiable manner, the other provisions such as polypharmacy regimens will not be successfully reduced. In order to improve documentation about evaluating and diagnosing individuals in a clinically justifiable manner, a new policy was designed called "Psychiatric Care & Services." This included a "Quarterly Psychiatric Medication Review Worksheet" to be completed by the assigned RN Case Manager, Psychologist, and QDDP prior to the QPMR meeting and used by the team during the meeting. The team should consider reviewing this type of information together via a projector/screen and typing the pertinent information <u>during</u> the clinic process. Of course, there would be some prep time ahead of the clinic that would be necessary to accomplish this task. Administration informed the monitoring team of the possibility of hiring a psychiatric nurse practitioner that would serve as a consistent psychiatric staff member. This individual in combination with the psychiatric assistants could serve in this capacity. The case formulations for quarterly 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. <u>Monitoring Team's Compliance Rating</u> MSSLC Self-Assessment summarized "only 64% of our individuals have been diagnosed	

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		in a clinically justifiable manner." The monitoring team's assessment is that evaluation, diagnosis, and justification for treatment with medication remained insufficient, therefore, this rating remains as noncompliance. The adequate completion of assessments was likely hampered by a lack of consistent and sufficient number of psychiatric resources.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	<u>Treatment Program/Psychiatric Diagnosis</u> Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medication in lieu of a program or in the absence of a diagnosis. While all individuals prescribed medication had diagnoses noted in the record, there were instances noted where the diagnoses provided by psychiatry differed from that included in other documents (i.e., PBSP). In the sample of 17 records reviewed, all 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. Per the facility self-assessment noncompliance was the rating for this provision item because only "78% of the Active Problem List identified the problems" that were the focus of treatment. 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 IDT will, it is hoped, generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and discuss strategies to reduce the use of psychopharmacologic medications. It was also imperative that this information is documented in the individual's record in a timely manner. It was notable that the BSP documents included information regarding the psychopharmacological regimen, medication side effects, and medication changes that were not developed in consultation with or collaboration with the individual's prescribing physician. This process further posed a systemic problem since the insufficient and inaccurate content of the medication information was then forwarded to the HRC for approval.	Noncompliance

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		Emergency use of psychotropic medications: The monitoring team was provided a numbered spreadsheet of individuals requiring utilization of chemical restraints in the last six months. There were 13 incidents with dates of incidents ranging anywhere from 8/21/11 to 2/11/12. These 13 incidents involved nine different individuals with one receiving four of the chemical restraints (Individual #491). The chemical restraint upon each administration was a combination of three different medications administered via intramuscular injection (Haldol 5 mg, Ativan 2 mg, and Benadryl 25 mg). This was a slight increase in incidents as last visit there were 10 incidents of chemical restraints involving seven different individuals. A review of the record of Individual #491 revealed that: • This individual received an additional chemical restraint 2/26/12 of a combination of three different medications administered via intramuscular injection (Haldol 5 mg, Ativan 2 mg, and Benadryl 25 mg) that was not captured in the data presented to the monitoring team. • Despite Individual #491 receiving a restrictive intervention of administration of chemical restraints, the ISP addendum dated 10/10/11 and 1/6/12 did not include the psychiatrist's signature as participating in the review. The absence of the psychiatrist in the ISP meetings resulted in a missed opportunity to foster strategies to reduce the use of emergency medication. • Documentation did not support efforts to utilize single agents instead of multi-agent restraints. Monitoring Team's Compliance Rating It was imperative for the IDT to attempt to utilize single agents for chemical restraints and monitor efficacy of the medication instead of utilization of multi-agent restraints. The different departments must communicate with one another for addressing utilization of restrictive measures (i.e., emergency chemical restraints) to allow for appropriate assessment and intervention to take place by the IDT.	
J4	Commencing within six months of the Effective Date hereof and with 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	Extent of Pretreatment Sedation A listing of individuals who received pretreatment sedation for either medical or dental clinic was requested, but the list given only included medical procedures. Nine individuals received pretreatment sedation for medical purposes from 8/15/11 to 1/24/12. The list consisted of eight different individuals (Individual #229 received sedation 11/3/11 and 11/9/11). Note, however, that this calculation did not include pretreatment sedation that was given	Noncompliance

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	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.	for dental purposes at an off-site dental clinic. This number should be incorporated into the MSSLC data set. No desensitization plans were implemented for the individuals who received pretreatment sedation for the medical procedure. Of the eight individuals listed that received pretreatment sedation, seven 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. Instead, the following was noted "the psychiatrist is available fully for consultative services, depending on who the medical care provider and the team decides who needs to be seen." Further, record review for Individual #597 noted, "no psychiatry notes or IDT meeting associated with the incident," for this individual who received Ativan 1 mg for medical procedure. This was similar to other cases, such as for Individual #303 for whom there was "no psychiatry notes or IDT meeting associated with this incident," for this individual who received Xanax 1 mg and Benadryl 25 mg for a medical procedure. Last review, 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 (26) or dental procedures (2) at MSSLC. <u>Interdisciplinary Coordination</u> Interdisciplinary coordination should review if adjustments to the individual's existing regimen could be made in an effort to reduce the duplication of medications administered. For example, individuals scheduled for pretreatment sedation may require a reduction in dosage of scheduled benzodiazepines in order to avoid over-medication. To date, interdisciplinary coordination was minimal as evidenced in the lack of documentation regarding this. Different departments were attempting to address this, sometimes in isolation and, therefore, there was a disjointed approach to this provision item. Recently, according to the director of psychology, there had been the development of a multi-disciplinary review process, including representation from various departments to begin interdisciplinary coordination (i.e., dentistry, primary care, psychiatry, and psychology) regarding this provision item. The facility should understand that the goal of this provision item is development of treatments or strategies to minimize or eliminate the need for pretreatment sedation. That is, formal desensitization programs may not be necessary for all individuals (though certainly will be necessary for some individuals). Processes developed at other DADS facilities (e.g., LSSLC) that may serve as a model.	

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		Desensitization Protocols and Other Strategies 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, Individual #372 had a desensitization plan implemented 12/27/11. The medical director informed the monitoring team that consent had not been obtained for individuals who received pretreatment sedation. Effective 2/1/12, there was a memo stating "all non-emergent cases of pretreatment sedation will be submitted to MRC for approval." While the memo was titled "Pretreatment Sedation Protocol," there was not an official document with a medical number and date of implementation of the official protocol. The monitoring team attended the MRC meeting during the visit. There was nothing mentioned in the MRC meeting in regards to cases of pretreatment sedation. If there were no cases to be presented then that information should be exchanged with the committee members and documented. The IDTs were beginning to address whether or not the individual required a desensitization plan in the ISP Addendum. 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. Monitoring After Pretreatment Sedation Since last visit, there was development of a nursing policy and procedure, with draft date 3/1/12 regarding pretreatment and post-sedation monitoring. The policy specifically outlined the steps for nursing staff to follow in regards to monitoring of vital signs, physical and mental status evaluations, and documentation in an acute care plan for individuals determined to need further monitoring for side effects. This was good to see (e.g., the process formalized in policy and procedure) for this complex issue of ensuring that each individual received an assessment when being administered sedating medications particularly when utilized in combination with other medications prescribed for medical and/or psychiatric conditions (that may have a negative clinical outcome). The clinical pharmacist would also be instrumental in providing the medication interactions and potential interactions of pretreatment sedation agents with concurrently prescribed medication. A review of provided documentation regarding the nursing follow-up and monitoring after administration of pretreatment sedation revealed that nursing documented assessment of the individual and vital signs. Monitoring Team's Compliance Rating This item will remain in noncompliance because further effort must be made with	

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		respect to the development of individualized treatments or strategies and/or desensitization protocols. Plans 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.	
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.	<u>Psychiatry Staffing</u> Approximately 70% of the census received psychopharmacological intervention requiring psychiatric services at MSSLC as of 3/26/12 (a total of 274 individuals). Of these, 57 individuals were age 18 or younger. There were a total of three FTE psychiatrists at MSSLC. The lead psychiatrist, appointed 2/3/12, was an employee of the facility. A locum tenens psychiatrist, board eligible in general psychiatry, was temporarily providing services at the facility from 3/12/12 until entering a child and adolescent residency in July 2012. There was another full-time equivalent locum tenens psychiatrist, board-certified that joined the psychiatry team 2/6/12. 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 IDT, ISPA, and other various meetings as needed. The medical director informed the monitoring team that four FTE psychiatrists would be required in order to allow the psychiatrist to provide care for an average of 60-70 individuals assigned to their caseload. The facility staff informed the monitoring team this would include enough time for the completion of the Appendix B comprehensive assessments, quarterly reviews, attendance at meetings (e.g., polypharmacy committee, IDT meetings, behavior therapy committee, physician's meetings, behavior support planning), other clinical activity, such as collaboration with primary care, nursing, neurology, other medical consultants, pharmacy, 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 provided phone consultation every week to the general psychiatrist (see J1). The facility should utilize the forensic and child psychiatrist to instruct the staff about an appropriate informed consent process in the medical/psychiatry department regarding psychopharmacological medication. <u>Administrative Support</u> There were two new designated full-time psychiatric assistants, Ms. Virginia Jackson and Ms. Bobbie Hall as of February 2012. 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 such as collection of pertinent data.	Noncompliance

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		Determination of Required FTEs Overall, it appeared that MSSLC had done an adequate job in assessing the amount of psychiatric FTEs required. Monitoring Team's Compliance Rating Per the facility self-assessment, MSSLC is approved for and supports the need for four full time psychiatrists. The facility provided a self-rating of noncompliance in the self-assessment for this item because of the inadequate number of psychiatrists. There were only three FTE psychiatrists at MSSLC at the time of the visit. The facility's history of inconsistent psychiatric staffing 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 to provide the services required, therefore, this provision remained in noncompliance.	
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.	Appendix B Evaluations Completed MSSLC reported that 181 individuals had psychiatric evaluations performed according to Appendix B. Given that 274 individuals received treatment via psychiatry clinic, an additional 93 individuals still required a comprehensive psychiatric assessment. Thus 66% of the evaluations, as described in Appendix B, had been completed. Given the remaining number of comprehensive psychiatric assessments this provision will remain in noncompliance. At the time of the last monitoring visit, 117 initial psychiatric evaluations had been completed for the individuals enrolled in psychiatric clinic. Thus, 64 comprehensive psychiatric assessments had been completed since then. The data indicated an average of 11 assessments were completed per month. Although progress was occurring, at this rate, it would take nine more months to complete all of them, without any new admissions to the facility. A sample of 10 Appendix B style evaluations performed in the previous six months was submitted and reviewed. The psychiatrist adequately completed the assessments, yet further information should be outlined in order to assist the IDT in regards to diagnostic clarification and selection of an evidence-based treatment plan for each psychotropic medication prescribed. While the format was followed for the Appendix B outline and reflected an improvement in documentation, there were some sections that required attention. • 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 individuals receiving psychotropic	Noncompliance

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		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 (e.g., hold the medication for pulse less than…), especially for individuals prescribed 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) 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. Other medical data, such as labs should be included, as well such as results of urine drug screen, chemistry profile, lipids, thyroid function test, etc. • The case formulation should identify detailed reasons for the justification of the chosen diagnostics 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. • Treatment recommendations also need to outline intention of each medication and to review potential drug-drug interactions and risk benefit analysis of the selection of the particular regimen. • The psychiatrist must guide the IDT 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. • Regarding specific evaluations: o Individual #600 had a review date on the first page of 9/29/11, but the last page of the evaluation noted a DR & DT date of 1/18/12. This indicated a time period of greater than three months between the review and when the evaluation was formally completed. (Also see the evaluation for Individual #590). o Individual #350 Axis II did not have any entry, even though this individual had "always been in special education classes." <u>Monitoring Team's Compliance Rating</u> The facility self-rated noncompliance due to Appendix B evaluations not being completed for individuals receiving psychiatric services. Given the remaining number of comprehensive psychiatric assessments this provision will remain in noncompliance.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive	<u>Reiss Screen Upon Admission</u> 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.	Noncompliance

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	functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The monitoring team received two different sets of data regarding this provision that conflicted. First, the psychology department submitted a list of new admissions/re-admissions and whether a Reiss was completed within 30 days that revealed the following: • The facility had 37 new admissions since last visit. Thirty-two individuals had a Reiss completed and the remaining five were scheduled for an evaluation within 30 days of their admission date. The monitoring team also received a document from the "Psych. Clinic," not dated, that indicated the number of new admits since last visit was 30 with only 22 Reiss screens completed. It was unclear if "psych" was psychology or psychiatry. The self-assessment noted the "Reiss database is maintained by psychology." Psychiatry should be aware of the findings of the Reiss screen in order to determine if the individual warranted psychiatric intervention. The two departments must share this vital information and have similar data. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> This was a difficult item to assess due to the presentation of the data. Given the data provided by two separate departments (i.e., psychiatry and psychology), it was difficult to determine which individuals were previously psychiatry clinic patients, those referred following a routine Reiss screen, and individuals screened due to a change in status or circumstance who then entered the clinic. For example, Individual #437's results of the Reiss noted, "does have a current need for psychiatric services," yet there was "N/A" in the psychiatric services column. Upon review of the psychiatry roster, Individual #437 was enrolled in the psychiatry clinic and received a comprehensive psychiatric evaluation. On the other hand, Individual #366 was deemed to have a need for psychiatric services and was admitted almost nine months ago, yet had not received a comprehensive psychiatric evaluation according to the "Appendix B as of 3/21/12" roster provided by the psychiatry department. This individual was enrolled in psychiatry clinic. 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. <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> The data did not specify the individuals who were referred for a psychiatric evaluation specifically due to findings of the Reiss Screen, however, the facility reported that all new admissions received a psychiatric evaluation. Thus, even though the Reiss was	

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		administered, the results did not determine whether or not an evaluation was to be completed (for new admissions). For individuals with a change in status, the use of the Reiss was less clear. The facility should become familiar with other state centers in regards to meeting the requirements of this provision particularly addressing time frames for those with an exacerbation of mental health symptoms following a change in status. Consideration should be given to reasonable time lines (e.g., within one week for initiation of consultation following a positive screen and no later than 30 days to complete the comprehensive psychiatric evaluation). <u>Monitoring Team's Compliance Rating</u> Given the challenges outlined inclusive of individuals with a psychiatric diagnosis or prescribed psychotropic medication not receiving a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis was warranted) in a clinically justifiable manner, this provision remained in noncompliance.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	<u>Policy and Procedure</u> The SSLC statewide policy and procedure dated 8/30/11 for psychiatry services had a title of "Integrated Care" summarizing that each state center must "develop and implement a system to integrate pharmacologic treatments with behavioral and other interventions through combined assessment and case formulation." <u>Interdisciplinary Collaboration Efforts</u> The monitoring team observed several psychiatric clinics. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (psychiatry, psychology, nursing, QDDP, direct care professional, and the individual). 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. 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. An IDT process (i.e., ISPA) essentially occurred within the psychiatry clinic, with representatives from various disciplines participating. <u>Integration of treatment efforts between psychology and psychiatry</u> Psychology and psychiatry need to formulate diagnoses and plans for the treatment of all individuals as a team. There was participation in the discussion and collaboration, but psychology did not consistently provide data of the essential <u>target symptoms</u> that were	Noncompliance

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		deemed necessary for monitoring of the current psychiatric diagnosis. This was the result of the psychiatrist not focusing on the particular psychiatric diagnosis and the reason the medication was prescribed. Instead, the IDT inquired predominantly about behavioral presentation, such as aggression towards others and SIB. Further, depending on what document was reviewed, there were varied diagnoses assigned between disciplines. Collaboration should be evident in psychiatry clinic, the psychiatric treatment plan, psychiatric assessments, the ISP process, the PBSP process, and, hopefully, with other interventions and disciplines (e.g., speech, OT/PT, medical). 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. There was minimal discussion during the psychiatric clinics regarding results of objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions. <u>Coordination of behavioral and pharmacologic treatments</u> There was cause for concern specifically with regard to the lack of a system for integration of pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. There was varied documentation of diagnostics due to inconsistent review between disciplines. For example, for Individual #539: • 7/26/10: In the Appendix B evaluation, a diagnosis of PTSD, physical and sexual abuse of a child, and conduct disorder was given. The psychiatrist commented, "strongly suspect…going to need individual therapy for the abuse." • 9/20/11: The psychiatric documentation indicated that Zyprexa 15 mg/day was prescribed for agitation and behaviors and Sertraline 75 mg/day was prescribed for anxiety. • 12/22/11: The PBSP listed diagnosis on Axis I (i.e., Bipolar Disorder, NOS) that did not match psychiatry diagnosis assigned (i.e., Anxiety Disorder) that was listed as an active diagnosis per psychiatry. • 12/27/11: The Quarterly Psychiatric Medication Review per psychology noted that Individual #539 appeared "stable and happy the greater majority of the time." • This youth suffered from obesity, increased lipids, and increased glucose,	

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		according to the physician's annual medical review dated 12/1/11, but he continued to receive an agent, such as Zyprexa that can cause these side effects. Additionally, the nursing assessment prepared for the psychiatrist dated 12/23/11 indicated that the individual's weight worsened. That should have further prompted the team to further review if the psychopharmacologic regimen was warranted. The psychiatrist's handwritten notes about the tracking data from psychology focused on variables (i.e., behavioral problems/ SIB) instead of selection of medication to target an Axis I Disorder from an evidence-based approach. There were, however, the beginnings of integration between psychiatry and psychology, specifically opportunities for interaction during psychiatry clinic with the psychologist and other disciplines. It was 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 occurred without the integration and support of the IDT, 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. <u>Monitoring Team's Compliance Rating</u> Due to the paucity of completed combined assessment and case formulation, this provision remained in noncompliance.	
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	<u>Psychiatry Participation in BSP and other IDT activities</u> 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. Psychiatry, however, verbalized a willingness to become more involved. The psychiatry department disputed amongst themselves about whether the present arrangement of spending hours in the Behavior Therapy Committee (BTC) was the appropriate place to determine the least intrusive and most positive interventions for the individual's care. The lead psychiatrist advocated for the present arrangement, yet the recently recruited locum tenens psychiatrist did not agree with attending the BTC to serve the function of this provision. The psychiatrists were not familiar with most of the individuals being	Noncompliance

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	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.	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. Furthermore, there had been constant change of staff in the psychiatry department resulting in lack of knowledge about the individual's history and response to psychiatric treatment. 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. The monitoring team was present in the BTC committee and reviewed PBSPs that were presented. It was apparent that psychiatry had not assisted the psychology department in preparation of the document. The following example illustrated how psychiatry participation in the development of the BSP was necessary. Individual #270 was monitored for unusual behaviors, such as appearing lost or confused and for inappropriate elimination, that were not relevant to the diagnosis assigned. When the monitoring team inquired about the selection of these symptoms, the psychology staff replied, "I will take it out" instead of the committee acknowledging the purpose of the feedback. This individual, who had Schizoaffective Disorder, Bipolar Type, was noted to have difficulty with attendance at programming, aggressive outbursts, and avoidance of interaction with others, yet there was nothing documented to guide the IDT about whether such presentation was the result of an exacerbation of an Axis I disorder that would warrant further review of psychotropic medication or due to noncompliance secondary to other environmental contributants that would best be addressed via other interventions. <u>Treatment via Behavioral, Pharmacology, or Other Interventions</u> It was warranted for the treating psychiatrist to participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan. This provision item focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral or psychiatric) in order to decrease the reliance on psychotropic medication. Given the presence of the IDT in psychiatry clinic, the PBSP could be reviewed during regularly scheduled quarterly clinic, with additional reviews as clinically indicated. The monitoring team attended the BTC and noted 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 monitoring team attempted to ask a few questions to the psychology staff during the BTC, but the meeting was already burdensome due to numerous plans requiring approval. Further, the psychology staff found it difficult to process the psychiatrist's feedback in this setting. The monitoring team provided summary in last report encouraging the psychiatrist to	

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		meet with the IDT 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. ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports During one of the psychiatric clinics observed, the psychiatric staff and IDT engaged in discussion of non-pharmacological interventions provided to the individuals (e.g., utilization of a communication device for a nonverbal individual with autism whom at times responded positively to this non-pharmacological measure). It was positive to witness the IDT's efforts in thoroughly reviewing this type of pertinent information and non-pharmacological approach. Some of the documentation for the member's signature lines were typed which made it easier to determine if a psychiatrist was "in attendance for deliberation." The monitoring team encouraged the medical director, psychiatrists, and psychiatric assistants to develop a system to acknowledge the participation of the psychiatrists in the various meetings. The psychiatric database listed the dates of the individual's ISP 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., ISPs, ISPAs, PBSPs). Monitoring Team's Compliance Rating 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. Psychiatry and psychology must learn how they can assist each other toward the common goal of appropriate treatment interventions, both pharmacological and non-pharmacological. Therefore, this provision item was rated as being in noncompliance.	
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	Policy and Procedure 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 IDT 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"	Noncompliance

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	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.	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." <u>Quality of Risk-Benefit Analysis</u> Per staff interview and record review, there had been minimal change in practice with regard to this provision since the previous monitoring review. A current review of the records of 17 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. The psychiatry department must utilize the findings in the QDRRs to enhance clinical care of the individual. The QDRRs were available as an ongoing tool developed for systematic review for those individuals receiving medication, such as psychotropics (Section N). Additionally there were comments regarding the risk/benefit analysis for treatment with psychotropic medications and restrictive programming included in the PBSPs. These were authored by psychology staff and, therefore, did not satisfy the requirements of this provision item or meet generally accepted professional standard of care. The psychology department, medical director, and the psychiatry department were receptive to changing this process that was reviewed during the previous visit and summarized the last monitoring report. 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. The monitoring team attended the BTC committee and stressed the importance of the psychiatrist and the IDT reviewing the content of this provision and, further, that is was not adequate to have medications outlined with generic statements along with the restrictive programming plan that was in the documents reviewed. For example, there was similar language used for the medication plan, risk vs. risk and benefit vs. risk analyses, and risks of not providing intervention. For example, the risk of not providing this intervention was identical for Individual #510 and Individual #283. 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. The success of this process, however, will require a collaborative approach from the individual's treatment team inclusive of the	

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		psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring is provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician 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. <u>Observation of Psychiatric Clinic</u> The development of the risk/benefit analysis could be undertaken during psychiatry clinic. This 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. During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed some of the laboratory findings with the IDT, but did not thoroughly outline findings in the documentation in the records reviewed in the form of a risk/benefit analysis. In fact, for Individual #49, upon inquiry of the monitoring team about when the last EKG was obtained for this individual (who received Seroquel, an agent that affects the EKG), it had been 10 years ago according to staff. The protocols to monitor psychotropic medication must be revised to include the monitoring of EKGs for those receiving psychotropics for possible potential side effects (i.e., arrhythmia, heart attack, stroke). 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 <u>during</u> the clinic process. The psychiatric assistants were rarely present in the clinic during the week of the onsite review, most likely due to working on data collection and document retrieval for the monitoring team. A computer was in the psychiatry clinic but was not being utilized during the clinic. The QDDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. Recommendations include accomplishing this goal together with the IDT by holding lengthier clinics (e.g., 45-60 minute, 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	

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		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. Human Rights Committee Activities A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). Monitoring Team's Compliance Rating 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 effective, or potentially more dangerous, than the medication. The input of the psychiatrist and various disciplines must occur with supporting documentation in order for the facility to meet the requirements of this provision item.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Facility-Level Review System During a previous visit, the facility was under the impression that just the formation of the review system was sufficient to achieve substantial compliance. The monitoring team explained 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 (with a plan). The monitoring team attended the polypharmacy meeting during the onsite visit. The pharmacy director had provided the monitoring team with the number of individuals classified as receiving this type of regimen, yet no one knew how many individuals were actually prescribed psychotropic medication at MSSLC when the committee met. The facility-level data must include the overall information of how many individuals were prescribed psychotropics, and of these individuals, who received intra-class and/or interclass polypharmacy. For example, if 100 individuals received psychotropic medication and of those, 100 individuals were prescribed a polypharmacy regimen, then polypharmacy would be the treatment plan for 100% of individuals in the psychiatry clinic. Of course, some individuals may require a polypharmacy regimen, but this should not be the norm. As was discussed during the onsite review, in some cases, individuals will require polypharmacy and treatment with multiple medications that may be absolutely appropriate and indicated. The prescriber must, however, justify the clinical hypothesis guiding said treatment. This justification must then be reviewed at a facility level review meeting. This forum should be the place for a lively discussion regarding reviews of the	Noncompliance

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		justification for polypharmacy derived during psychiatry clinic. This element was missing, as the existing facility level review process was ill prepared, and attempted to run a psychiatry clinic clarifying diagnostics and case history as opposed to succinctly presenting findings to the committee. <u>Review of Polypharmacy Data</u> For onsite reviews by the monitoring team, it would be helpful for the facility polypharmacy review to always 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 psychiatrist. The polypharmacy information presented in the Pharmacy and Therapeutics Committee during the onsite visit noted that polypharmacy cases "continue to increase due to population changes." The clinical indicators outlined for the review were not reflective of evidence-based practice for evaluating efficacy of the selected medication regimen. The target symptoms did not consistently address whether the medication was prescribed for actual psychiatric symptoms (e.g., hallucinations and/or affective disturbance). Thus, the team could not accurately detect if the medications were effective for the identified psychiatric illness 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. <u>Review of Polypharmacy Justifications</u> A spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy (including medications in process of active tapering) and justification for polypharmacy dated 3/9/12 provided the names of only three individuals (Individual #109, Individual #300, and Individual #254). There were certainly more than three individuals who met the definition of intra-class polypharmacy with 100 individuals being classified as receiving interclass polypharmacy. This was yet another example of how the facility did not capture or utilize the necessary information that would drive the next step of the psychiatrist reviewing the case and treatment regimen within an IDT format in clinic and in other settings to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated. The review of the polypharmacy provided to the monitoring team (i.e., per document request, via polypharmacy committee, information provided upon inquiry by monitoring team in psychiatric clinics) was not an active exercise by the IDT to minimize	

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		unnecessary medications, but more of a response to an imposed requirement placed upon psychiatry as dictated by this provision item. At the polypharmacy committee, attendees had the burdensome task of listening to the presenting psychiatrist recite the individual's case history and other information that was not pertinent to the intention of the review, without the apparent leadership of how to approach such information. As noted in a prior monitoring report, the total number of individuals residing at the facility prescribed polypharmacy had increased from 54 in August 2010 to 86 in July 2011. The total was higher in December 2011 (100), January 2012 (101), and February 2012 (103). One individual listed in the summary (February 2012) received as many as six or more psychotropic agents with nine individuals prescribed five medications for psychiatric purposes, 28 individuals were prescribed four medications, 62 were prescribed three medications, and three individuals were prescribed two psychotropics. Upon further inquiry, the monitoring team learned that the medications for seizure disorder or other medical conditions were not included in this count, or even somehow included in a report or summary about polypharmacy at MSSLC. 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 were imperative in order to avoid further drug-drug interactions for those already prescribed numerous medications. Thus, the importance of ongoing monitoring for side effects, reporting of adverse drug reactions, and review of finding of the QDRRs (section N) remained very important. <u>Monitoring Team's Compliance Rating</u> Given the ongoing challenges noted above with regard to the need for an established system level of review of polypharmacy justifications, this provision was rated in noncompliance.	
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	<u>Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS)</u> Per the self-assessment it was noted "there is not a plan in place to adequately monitor this." This was another example of the different departments not communicating with one another. In response to the document request for a spreadsheet of individuals who have been evaluated with MOSES and DISCUS scores, the facility provided information regarding scores and dates of completion of evaluations dated September 2011 through March 2012. Review of this information revealed delay in completion of the DISCUS given that the goal was administration every three months. For example, Individual #354, Individual #471, Individual #524, Individual #420, Individual #307, and Individual	Noncompliance

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	and/or changing needs, but at least quarterly.	#106 each had a MOSES and DISCUS administered in November 2011, yet there was no follow-up MOSES and DISCUS entry since then for any of these individuals. Clarification was required because training documentation provided to the monitoring team noted that this standardized assessment was to be administered every three to six months. The "The Big 10" section for side effects monitoring stated the standardized side effects assessment instrument "should also be done within one month of starting, adding, or changing to any new psychopharmacologic medication." It would be helpful to identify the reasons for not obtaining a follow-up with N/A and notation if the individual was discharged from the facility or was no longer receiving psychotropic medication, if this was the case. It was good to see that the nursing staff had designed the database to reflect this pertinent information. Psychiatry must utilize this information and work together with nursing to make this process clinically applicable and request the updated information if the individual have not been administered the screens for the purpose of monitoring potential side effects of psychotropic medication. <u>Training and Clinical Application</u> For facility nursing staff, training occurred 2/28/12 and 2/29/12. A total of 17 nursing staff participated in the training. The facility has been making efforts, as such, to address this vital section. The monitoring team posed questions to numerous medical staff inclusive of nursing and psychiatrists about the steps one would take once an adverse drug reaction was detected. There were various answers given to the monitoring team, but no one cited that the adverse drug reaction should be reported as outlined in the medical services policy and procedure. In fact, most of the medical staff did not know the definition of an adverse drug reaction (e.g., unexpected, unintended, undesired, or dangerous effect that a drug may have that occurs at doses used in humans for prophylaxis). It was imperative to include training of ADR reporting, preferably with the training that occurred with the MOSES/DISCUS screening, in order for staff to associate that the purpose of the monitoring/detecting flows into the reporting requirement. <u>Quality of Completion of Side Effect Rating Scales</u> 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 IDT did not understand the importance of actually reporting, such as by filling out an ADR. During the ISP meeting for Individual #127, a nursing staff reported a situation that should have resulted in the reporting of an ADR, however, the IDT 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, the impact from a medical and legal perspective when entered incorrectly in the medical record, and	

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		planned to attend to this topic. The names of 11 individuals were provided to the monitoring team that had the diagnosis of tardive dyskinesia (TD), however, upon physician's review of the actual scales, the neurologist and/or psychiatrist noted that they did not have TD. All were enrolled in psychiatry clinic and three of the individuals (i.e., Individual #140, Individual #376, and Individual #61) were followed by the neurologist. The report of only 11 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. The knowledge about the history of exposure to prescribed medications, such as neuroleptics and metoclopramide, was also necessary to assess the risk of TD. Last review, there were four individuals diagnosed with TD. Although medications, such as antipsychotics and metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements (i.e., 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. <u>Monitoring Team's Compliance Rating</u> Given the need for the demonstration of the consistent identification of individuals (i.e., obtaining and applying pertinent medical history discovered about exposure to medications that cause TD) experiencing side effects and the need for the appropriate utilization of this information in clinical decision-making, this provision was rated as being in noncompliance. It is recommended that the psychiatric department work with the nursing department to address this provision.	
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	<u>Policy and Procedure for Psychiatric Services</u> Per a review of the DADS statewide policy and procedure "Psychiatry Services," effective 8/30/11, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." In section 7.b., the policy directly quoted the language in this provision item. MSSLC document scanned 3/9/12 noted "Psychiatry Services policy has not been revised since last visit." This was in conflict to the monitoring team being informed that MSSLC had implemented a facility-specific policy and procedure entitled "Psychiatric Care & Services" that outlined the requirements for "Participating in Quarterly Psychiatric Medication Review Meeting."	Noncompliance

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	for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	It was progress that the facility developed pertinent policy and procedures, however, staff knowledge and implementation was not yet apparent. For example, upon observation during the psychiatry clinic, an exchange between a psychiatrist and psychologist, revealed that staff were not aware of the most recent procedure of exchanging data. Upon inquiry about the details of the statewide and facility policies for psychiatric services, the psychiatry team was not able to explain the clinical relevance or differences that existed between the documents. The sharing of information between disciplines was particularly problematic due to the numerous staff changes that occurred in the psychiatry department. There was not adequate transitioning reflected by lack of training of the new staff and inadequate delegation of their responsibilities. The psychiatric assistants informed the monitoring team that they were not certain of their job description. The lead psychiatrist frequently referred to the medical director as having the responsibility of oversight of the clinic and became defensive upon inquiry by the monitoring team. Clearly, there was no leadership in monitoring of psychiatric services at MSSLC at the time of this review. <u>Treatment Plan for the Psychotropic Medication</u> The treatment plan for the psychotropic medication would have to be designed in concert with accurate diagnostics. The facility has not yet implemented a system of monitoring revision of diagnostics. Per record review, it was noted that the facility had "a plan for having this information available for the next visit." If a psychiatrist changes a diagnosis, the IDT should be aware of the reasons for the choice of the new diagnosis over the old one, and allow the IDT to change the treatment plan accordingly. The facility must understand that the document request was not designed for the monitoring team. The information requested should be the practice of the delivery of care reviewed consistent with generally accepted professional standards of care. The facility's action plan noted the Quarterly Medication Review process was revised since last visit to allow for various disciplines to submit written data at every Quarterly Medication Review. Per the facility's self-assessment, there was 55% compliance in regards to addressing expected timeline for therapeutic effects to occur, 79% compliance with identification of objective psychiatric or behavioral characteristics, and 69%"compliance for identification of who, when, and how often monitoring would occur. A review of documentation inconsistently justified 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	

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		records. Psychiatry Clinic During the monitoring review, several psychiatry clinics were observed. For Dr. Brown's clinic (held at the same time of Dr. Kirby's clinic) the first individual scheduled for evaluation was not present due to a conflict with mandatory school testing. The psychiatrist and IDT were not aware of this being an issue until the beginning of the clinic. Communication with the IDT and efficacy of running the clinic should be a function of the psychiatric assistants and support staff. Surprisingly, no member of the IDT, inclusive of the psychiatrist, seemed to be concerned this last minute change. In another instance, in Dr. Vega's psychiatric clinic, the QDDP was late and the team patiently waited. The IDT informed the monitoring team that they would have to reschedule the meeting if the QDDP did not show, but eventually she arrived and was apologetic. The psychiatric assistants were not always in attendance in the clinic and, therefore, were not able to coordinate and address these issues. Both of the psychiatric assistants were receptive to feedback from the monitoring team and were learning their newly appointed roles in the scheduling and coordination of psychiatric services. Even given the above, all treatment team disciplines were represented during each clinical encounter that was observed. Further, the teams did not rush clinic, spending an appropriate amount of time (i.e., 30 minutes) with the individual and discussing the individual's treatment. Medication Management and Changes 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. There were some improvements noted regarding exchange of pertinent information during some of the psychiatric clinics, however, the data predominantly focused on behavioral presentation (e.g., 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. • Unfortunately, adequate consent was not appropriately obtained by a	

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		physician/psychiatrist • This provision item specifically requires that the IDT, 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. • As previously mentioned, the protocols for monitoring EKG for individuals receiving atypical antipsychotics required revision and implementation • The QDRR was a beneficial tool to reference during psychiatric clinic, but was not utilized in this fashion • The QPMR form did not allow adequate writing space for the psychiatrist to complete documentation contributing to illegible handwriting, and did not include all of the medications, just psychotropic medications. It would be best to have a typed template that would serve as the master copy of diagnostics, case formulation, treatment plan, etc. 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. This was nicely illustrated in one case example during the monitoring visit provided by Dr. Vega. Dr. Vega noted that Individual #49 had diagnoses inclusive of a seizure disorder, an autistic disorder, and intermittent explosive disorder. This individual received an atypical antipsychotic and an AED medication. Dr. Vega explained to the monitoring team that the presenting symptoms of the individual would best be explained secondary to the autistic spectrum therefore concluded that the diagnosis of intermittent explosive disorder was not warranted. Additionally, Dr. Vega ordered a neuropsychiatric consultation to discuss the necessity of Depakote since the IDT decided that the only agent necessary to target the Axis I Disorder of autistic disorder was Seroquel. This was a good example of establishing a revision of diagnostics and clarification of the indication of the medication selected. 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.	

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		Monitoring Team's Compliance Rating Per a review of the facility self-assessment, this provision was rated in noncompliance. A review of a sample of 17 records revealed varying quality in documentation for the psychiatric reviews, with most of the deficiencies noted in the identification of a clinically justifiable diagnosis to ensure that the treatment plan for the medication was consistent with generally accepted professional standards of care. Therefore, the facility remained in noncompliance for this item.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Policy and Procedure 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 director of psychology informed the monitoring team that psychology obtained consents for psychotropic medications. 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). Both the medical and psychology departments were receptive to the prescribing physician being responsible for obtaining consent for psychotropic medication. The monitoring team is in agreement with this plan. As noted in the self-assessment, "psychiatry has been waiting for a state policy addressing medications so that they may have guidelines. At this time, state office has not presented such policy. Each psychiatrist has taken a different approach to obtaining consents." During the last visit, the monitoring team met with Ms. Benson, the past interim facility director, to discuss the topic of consent for psychotropic medication and the need for the facility to handle this as a medical consent. Ms. Benson was receptive to the feedback from the monitoring team, however, this change had not been fully implemented, perhaps in part due to the appointment of a new, permanent facility director. Current Practices Based on some of the discussions between the psychiatry staff at MSSLC and 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. The transition was not reflected in the document review provided as illustrated in the consent form for Individual #90, an individual who was admitted this year. The necessary components of consent were not addressed. The form noted "Benefits and Risks of Program" with the same identical language for every medication, instead of the actual benefit and risks of each medication being cited. The following was the repeated	Noncompliance

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		language for benefits and risks of the program: "Increase participation in Life, Social, and Training Activities and Improved Relationships with others." IDT signature sheet for the ISP held in February 2012 did not include a psychiatrist in attendance. The content of the consent form was similar for all of the different medications prescribed, thus a copy and paste exercise for the most part. The name of Individual #560 was provided for the monitoring team's request of families/LARs who refused to authorize psychiatric treatments and/or medication recommendations. It was not clear why the individual continued to be offered medication when the LAR refused to authorize the treatment according to the data presented to the monitoring team. The monitoring team recommended revision of the consent form last review and that had not occurred. The blank consent form did not include all of the necessary components of an informed consent procedure for medication. For example, alternatives and associated risks, 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." Further, the form should have a section on the benefits and risks of the medication, not only on the benefits and risks of the program (also see section J4 above). 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. 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. Further, of note, upon interview with the medical director, consent was not obtained for pretreatment sedation. 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. This should not preclude the facility from proceeding with implementation of informed consent by the physician because a psychiatrist should be competent in this task without	

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		the direction of a specific policy and procedure. 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. <u>Monitoring Team's Compliance Rating</u> This provision remained in noncompliance due to the inadequate informed consent practices noted above.	
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.	<u>Policy and Procedure</u> Per DADS policy entitled, Psychiatry Services, #007.2 dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the IDT process, when the medications are prescribed to treat both seizures and a mental health disorder." A review of documents, including facility policy and procedure regarding psychiatric treatment, did not reveal additional policy and procedure regarding this issue. <u>Individuals with Seizure Disorder Enrolled in Psychiatry Clinic</u> The monitoring team received a numbered alphabetized list of 25 individuals participating in psychiatry clinic who had a diagnosis of a seizure disorder. Last visit, there were 53 individuals, a data difference of 28 individuals. There was concern about the accuracy of this count of individuals who would require the coordination of care by a neurologist and a psychiatrist to treat both seizures and a mental health disorder. <u>Adequacy of Current Neurology Resources</u> Per interviews with the facility medical director, there had been efforts to coordinate care with neurology. There were monthly scan calls with the Scott & White Hospital neurology department to discuss individuals with intractable seizures. In regard to a record request for the schedule of the consulting neurologist, the monitoring team received the following: Dr. Cowens started in February 2012 and held clinic for 8 hours each on 2/6/12, 3/5/12, and 4/2/12. Otherwise individuals were referred to Scott and White and evaluated by Drs. Kirmani, Borucki, or Creel. Individual #31 was reviewed via scan call with the neurologist from Scott and White because this individual had intractable epilepsy. Individual #31 was also enrolled in psychiatric clinic. The neurologist provided consultation via telephone to the PCP and	Noncompliance

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		psychiatry that was a good beginning for the goal of coordination of the individual's care. Unfortunately, during the scan call, the staff at MSSLC did not have a list of all of the individual's current medications available until prompted by the monitoring team. The initial focus was only about the AED regimen, however, when one medication is changed it can affect the level of the other medication prescribed, inclusive of but not limited to the psychotropic regimen (i.e., increase or decrease). If done correctly, this type of consultation would meet the criteria for a Neuropsychiatric consultation because it required the participation of a neurologist and a psychiatrist. Drug regimen and drug interactions require thorough review particularly for individuals with intractable epilepsy and how this may impact the seizure disorder and mental status presentation. During the discussion with the neurologist, one of the medications that were prescribed, Trileptal, was not mentioned for Individual #31 until later in the meeting with the neurologist. It was not clear to the monitoring team why the whole case picture of the individual was not presented. 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. It was imperative for everyone participating in the conference call to have a current list of all medications, the individual's medical record, neurology record, psychiatric information, etc. to make informed decisions about necessary medication regimen and indications for the all of the medications. The team was perplexed about the indication of the Trileptal for this individual with intractable epilepsy and thought it may have been prescribed as a psychotropic. Upon inquiry of the involvement of psychiatry during the neurology clinics, the monitoring team was informed that the psychiatrist was available to speak with the neurologist at the end of the consultation. This defeats the whole purpose of the neurologist and the psychiatrist coordinating the use of medications when they are prescribed to treat both seizures and a mental health disorder. The indications for the medications need to be discussed because an AED for seizure disorder may not be warranted for the Axis I disorder and, therefore, the indication would only be for the seizure disorder. There was a pervasive pattern noted throughout the record review and upon observation of the psychiatric clinics and team meetings that numerous individuals received an AED medication, yet the team was not able to confidently state the purpose of the medication. This individual's presenting symptoms of breakthrough seizures and psychiatric disorder represented the necessity of the neurologist and psychiatrist for the coordination of the use of medications, through the IDT, when they were prescribed to	

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		treat both seizures and a mental health disorder. The recommendation to discontinue a medication, such as a benzodiazepine (depending on dosage, etc.) or an AED prescribed for an Axis I disorder may result in occurrence of increased frequency of seizure activity because these medications also target seizures. Thus, the psychiatrist should obtain consultation with the IDT, including the neurologist, prior to discontinuation of an anti-epileptic agent, particularly for individuals with a seizure disorder. Similarly, the neurologist choosing an agent without the psychiatrist is not be best practice 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 while monitoring seizures, side effects, drug-drug interactions, and mental status. <u>Monitoring Team's Compliance Rating</u> The facility remained in noncompliance with this provision item due to the lack of identification of target symptoms for AED regimen that must occur between the neurologist and the psychiatrist. The neurologist and psychiatrist must coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	

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. Onsite consultation 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 (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. 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. The lead psychiatrist should develop a system level of integration between the psychiatric practitioners and psychology staff (J2, J3, J4, J8, J9).

5. Develop a recruitment/retention plan for psychiatry (J1, J2, J5, J14, J15).

6. The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to psychopharmacologic interventions, and the monitoring of specific clinical indicators to determine the efficacy of the prescribed medication (J2, J8, J13).

7. Integrate the prescribing psychiatrist into the overall treatment program at the facility as follows (J3, J8, J9, J13):
    a. Utilize the psychiatric treatment plan for psychotropic medications written per the psychiatrist in the overall team treatment plan;
    b. Ensure the individual's psychiatric diagnosis is consistent across disciplines;
    c. In discussions regarding treatment planning and behavioral support planning;
    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.

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

9. 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 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 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 IDT. The team integration should be measured via consistency in the records across disciplines.

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

11. 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).

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

13. All lists and data submitted to the monitoring team must include a date, title, and department submitting the information 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, J4, J6, J7, J11).

14. The facility to determine the mechanism for referral and documentation for those individuals requiring a psychiatric evaluation following a positive Reiss Screen or following a change in psychiatric, behavioral, and/or medical status (J7).

15. The facility to address the deficits as outlined in the report regarding informed consent process for psychotropic medications (i.e., prescribing practitioner responsibility; revision of consent form to include all of the necessary components). In an effort to address the deficit regarding informed consent practices, it is recommended that the facility also 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).

16. Psychiatry to author the risk versus benefit for each the 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).

17. The psychiatrist should utilize the findings obtained via the polypharmacy review committee and the QDDR as it relates specifically to the medication regimen prescribed for each individual. 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).

18. The facility must consider options for implementing neuropsychiatric clinic consultation. It would be beneficial to determine the amount of clinical neurology and psychiatry time needed via an examination of the number of individuals requiring review when prescribed medication to treat both seizures and a mental health disorder. 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 (J3).

20. To adequately complete self-assessments, collect data such as number and percentage of meetings attended by the psychiatric staff (i.e., ISPs, ISPAs, PBSPs, etc.). The psychiatric database lists the dates of the individual's ISP 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).

21. Consider the use of typed notes, projectors for clinic data, and other means of making the psychiatric service provision more efficient (J2, J10).

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:** Documents Reviewed: o Functional Assessments for: • Individual #401 (8/30/11), Individual #143 (10/25/11), Individual #388 (11/22/11), Individual #479 (11/23/11), Individual #279 (12/20/11), Individual #367 (2/7/12), Individual #199 (01/27/12), Individual #126 (3/19/12) o Positive Behavior Support Plans for: • Individual #65 (9/6/11), Individual #570 (2/24/12), Individual #202 (3/14/11), Individual #519 (9/14/11), Individual #491 (12/21/11), Individual #126 (3/20/12), Individual #469 (9/1/11), Individual #54 (10/21/11), Individual #360 (9/20/11), Individual #575 (10/3/11), Individual #502 (9/16/11), Individual #209 (10/24/11), Individual #572 (11/3/11), Individual #367 (12/20/11) o Six months of notes on PBSPs progress for: • Individual #54 (10/21/11), Individual #360 (9/20/11), Individual #575 (10/3/11), Individual #502 (9/16/11), Individual #209 (10/24/11), Individual #572 (11/3/11) o Full Psychological Assessments for: • Individual #514 (12/27/11), Individual #87 (3/20/12), Individual #63 (12/29/11), Individual #491 (1/11/12), Individual #279 (1/13/12), Individual #494 (1/19/12), Individual #504 (1/23/12), Individual #51 (1/27/12), Individual #350 (2/12/12), Individual #342 (2/3/12), Individual #325 (2/6/ 12) o Annual Psychological updates for: • Individual #71 (12/21/11) o STARS-Anger Management treatment plans for: • Individual #Individual #100, Individual #508, Individual #284, Individual #598, Individual #595, Individual #431 o STARS-Group Counseling treatment plans for: • Individual #426, Individual #489, Individual #510, Individual #253, Individual #583, Individual #267, Individual #10, Individual #64, Individual #17, Individual #536, Individual #21, Individual #137, Individual #195, Individual #144 o STARS-Individual Counseling treatment plans for: • Individual #367, Individual #126, Individual #169 o List of individuals who are receiving counseling/psychotherapy, undated o List of annual psychological assessments completed in the last six months, dated 3/14/12 o List of individuals for whom a functional assessment has been completed in the last six months, dated 3/9/12 o List of individuals dates of psychological assessments, dated 3/9/12 o Data Pilot Project: IOA Data, undated

	o IOA Project presentation, undated o Section K Presentation Book, dated 3/12/12 o List of psychology department staff and status of enrollment in BCBA coursework, undated o MSSLC Self-Assessment, Section K, dated 2/21/12 o MSSLC Action Plans, Section K, dated 3/15/12 o Internal Peer Review minutes, dated 9/21/11, 9/28/11, 10/12/11, 10/19/11, 11/3/11, 11/9/11, 11/23/11, 12/7/11, 12/14/11, 12/28/11, 1/4/12, 1/11/12, 1/20/12, 2/3/12, 2/8/12, 2/15/12, 2/22/12 o External Peer Review minutes, dated 9/13/11, 10/28/11, 11/30/11, 12/23/11, 1/27/12 o Psychology Department Weekly Data Collection Form, dated 4/10 o List of individuals with a PBSP o Hogg Foundation Training presentation, dated 2/12-22/12 o Performance Evaluation Team (PET) I meetings, dated 12/11, 1/12, 2/12, 3/12 o Graphs of PBSP reading level for 8/11, 9/11, 10/11, 11/11, 12/11, 1/12, 2/12 o A list of all training conducted on PBSPs, dated 2/29/12 <u>Interviews and Meetings Held</u>: o Charlotte Kimmel, Ph.D., Director of Psychology o Ray Mathieu, BCBA o Lupita Alfaro, Psychology Assistant o Psychology Department o Polly Bumpers, John Parks, Troy Miller, Bertha Allen, and Barbara Shamblin, Unit Directors o Functional Assessment Presentation by the monitoring team • Staff present: Charlotte Kimmel, Director of Psychology Services; Xiaodong Zhang, Psychologist; Lupita Alfaro, Psychologist Assistant; Andrew Griffin, Psychologist; Ora Davis, Psychologist; Michael Miller, Psychologist; Ray Mathieu, BCBA; Chris Christensen, Psychologist; Elizabeth Kadin, Psychologist; Molly Chase, Psychologist; Clint Dennard, Psychologist; Trey Stubbs, Psychologist; Steven Parkhurst, Psychologist; Gerry Reaves, Psychologist; Crystal Duncan, Psychologist <u>Observations Conducted</u>: o Stars Task Force • Staff Present: Lisa Jones, Psychology Assistant; Charlotte Kimmel, Director of Psychology Services; Molly Chase, Psychologist; Richard Boyer, Assistant Director of Psychology; Lupita Alfaro, Psychology Assistant; Andrew Griffin, Psychologist; Gerry Reaves, Psychologist; Donna Porter, Psychologist; Michael Miller, Psychologist; Nedra Francis, Assessment Psychologist o Behavior Therapy Committee Meeting • Staff Present: Charlotte Kimmel, Director of Psychology Services; Molly Chase, Psychologist; Amy Diller, BCBA Consultant; Nedra Francis, Assessment Psychologist; Norvell Starling, MISD/MSSLC Liaison; Chris Christensen, Psychologist; Xiaodong Zhang, Psychologist; Lupita Alfaro, Psychologist Assistant; Andrew Griffin, Psychologist; Elizabeth

	Kadin, Psychologist; Frances Harman, SLP: Judy Haymen, Psychology Secretary • Individuals Presented: Individual #570, Individual #202 o Internal Peer Review Meeting • Staff present: Charlotte Kimmel, Director of Psychology Services; Xiaodong Zhang, Psychologist; Lupita Alfaro, Psychology Assistant; Andrew Griffin, Psychologist; Gerry Reaves, Psychologist; Ora Davis, Psychologist; Michael Miller, Psychologist; Ray Mathieu, BCBA; Chris Christensen, Psychologist; Elizabeth Kadin, Psychologist; Molly Chase, Psychologist; Amy Diller, BCBA Consultant; Richard Boyer, Assistant Director of Psychology • Individual presented: Individual #126 o Anger Management group • Staff facilitators: Trey Stubbs, Psychologist; Tiffany Watson, Behavior Therapist • Individuals participating: Individual #386, Individual #539, Individual #137, Individual #127, Individual #183, Individual #65 o Psychiatric Clinic • Staff present: Dr. Brown, Psychiatrist; Suzanne Stull, RN; Tammy McCullach, Vocational Ed; Clint Dennard, Psychologist; Kelly Mathews, DCP; Andrea Smith, QDDP; Lupita Alfaro, Psychology Assistant • Individual presented: Individual #466 o Psychiatric Clinic • Staff present: Dr. Brown, Psychiatrist; Lupita Alfaro, Psychology Assistant; Stephanie Griffin, DCP; Andrea Smith, QDDP; Clint Dennard, Psychologist; Shirley Freeman, RN • Individual presented: Individual #74 o ISPA Meeting • Staff present: James Smith, QDDP; Gordon Bansley, RN; Zusele Quile, Psychologist; Lupita Alfaro, Psychology Assistant; Carmen Saey, Psychology Assistant; Courtney King • Individual presented: Individual #65 o Data Project Presentation • Staff present: Charlotte Kimmel, Director of Psychology Services; Lupita Alfaro, Psychology Assistant; Michael Miller, Psychologist; Ray Mathieu, BCBA; Richard Boyer, Assistant Director of Psychology; Molly Chase, Psychologist; Clint Dennard, Psychologist; Gerry Reaves, Psychologist; Donna Porter, Psychologist o BCBA Supervision meeting • Staff present: Ray Mathieu, BCBA; Charlotte Kimmel, Director of Psychology Services; Ora Davis, Psychologist; Molly Chase, Psychologist; Clint Dennard, Psychologist; Trey Stubbs, Psychologist; Steven Parkhurst, Psychologist; Crystal Duncan, Psychologist; Gerry Reaves, Psychologist 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.

	Facility Self-Assessment: MSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document, separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the self-assessment included relevant activities in the "activities engaged in" sections. It should include, however, activities that are in line with what the monitoring team assesses as indicated in this report. For example, for K4, the self-assessment reported that behavioral staff "completed 50 Section K self-monitoring tools…" and reviewed 11 progress notes. The facility rated that 92% of these items met the provision requirements. The self-monitoring tools, however, do not weigh items and, therefore, it is not clear what 92% compliance really meant. As the report below indicates, the critical items for K4 (and, therefore, the items that should be reviewed in the self-assessment) are: • A data system that includes the collection of target and replacement behaviors. • A data system that is simple and flexible. • Evidence that data collection is reliable. • Evidence that interobserver agreement (IOA) is collected, reliability goals are established, and attempts are made to ensure that those goals are achieved. • Graphing of data and progress review occur at least monthly, with more frequent graphing as necessary. • Evidence of progress, or evidence of some activity (e.g., modification of PBSPs, retraining of staff, etc.) to address lack of progress. • Evidence that data are used to make treatment decisions in psychiatric clinics, peer review meetings, ISP meetings, etc. Finally the self-assessment did not include what, in particular, was reviewed in the progress notes. To take this process forward, the monitoring team recommends that the self-assessment review, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the psychology department to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other.

	Even though more work was needed, the monitoring team wants to acknowledge the efforts of the psychology department and believes that the facility was proceeding in the right direction. This was a good first step. MSSLC's self-assessment indicated that three items (K2, K3, and K8) were in substantial compliance. The monitoring team's review of this provision was is in agreement with substantial compliance for items K2 and K3. The monitoring team found K8, however, to be improved, but not in substantial compliance. The self-assessment 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: 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: • Increase in the percentage of staff who write Positive Behavior Support Plan (PBSPs) that are enrolled in coursework toward attainment of board certification in applied behavior analysis (K1) • Establishment of the collection of inter-observer agreement data (IOA) data (K4) • Improvements in the overall quality of functional assessments (K5) • Continued development 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). The monitoring team suggests that the facility focus on the following areas during the next six months: • Ensure that the service plans for all group and individual therapies include procedures for generalization of acquired skills (K8) • Expand the collection of IOA data for target behaviors, establish IOA target levels, and ensure achievement of those levels (K4) • Develop a method to ensure that PBSPs are implemented with integrity (K11) • Ensure that all functional assessments include 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, at the time of the onsite review, the majority of psychologists at MSSLC who wrote Positive Behavior Support Plans (PBSPs) were not certified as applied behavior analysts (BCBAs). The facility, however, continued to make improvements in this area. At the time of the onsite review, one psychologist was a BCBA, and three psychologists were eligible to sit for the national examination necessary for attaining BCBA. Additionally, 11 psychologists were enrolled in course work toward becoming BCBAs. Two of the department's 14 psychologists who wrote PBSPs (14%) were not BCBAs, approved to sit for the national BCBA exam, or enrolled in BCBA coursework at the time of the onsite review. This represented an improvement from the last review when 37% of the psychologists who wrote PBSPs were not BCBAs, approved to sit for the national BCBA exam, or enrolled in BCBA coursework. The facility provided supervision of psychologists enrolled in the BCBA program by contracting with a consulting BCBA from the community, and by using the one BCBA in the psychology department. To achieve substantial compliance with this provision item, the department needs to ensure that all psychologists who write 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 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 continued to be in substantial compliance with this item. MSSLC continued its weekly internal, and monthly external, peer review meetings. 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 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 Individual	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		#126's functional assessment. The peer review meeting included active participation from the majority of the department's psychologists, and appeared to result in a better understanding of the antecedents and consequences of Individual #126's target behaviors. Review of minutes from internal peer review meetings indicated that the majority of psychologists in the department regularly attended 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 continued improvements regarding this provision item since the last onsite review. In order to achieve substantial compliance, however, the facility needs to ensure that data are reliable by expanding the collection of interobserver agreement (IOA) data, establishing acceptable IOA levels, and ensuring that those levels are achieved. Additionally, the facility needs to collect data collection reliability, establish acceptable levels, and ensure that those levels are attained. Finally, the facility needs to ensure that data are routinely used to make data based treatment decisions. The facility had expanded the simplified data system to all individuals and homes at MSSLC. In this 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 during the shift, and determine if DCPs were recording data at the intervals specified during that shift. As in past reviews, 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 continued to be discouraging: • The target and replacement behaviors sampled for only one (B1) of six data sheets reviewed (17%) were completed up to the previous hour. Moreover, some of these sheets were not initiated at all for the shift observed. This is somewhat better than the last review when only 8% of the data sheets were recorded up to the previous hour.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Additionally, the data sheet in one home (S1) was filled out until 10 pm, however it was reviewed at approximately 7:30 pm. These observations indicated that DCPs were not consistently recording target behaviors. This is potentially a serious problem because, if the DCPs are waiting to record data until the end of the shift (or recording anticipated data), they are not likely to record accurate data and, therefore, the psychologists cannot evaluate the effects of their interventions. The regular monitoring of data collection reliability, as described above, is one simple and time efficient measure of data reliability. It's usefulness is limited to observations made in the treatment site (that is, simply reviewing completed data sheets would not indicate when they were filled out), however, being in the treatment site and discussing with DCPs why they were not recording data immediately after each interval would likely improve the timeliness of data recording. It is, therefore, recommended that the facility begin to collect and track data collection reliability. Additionally, data collection reliability goals should be established, and DCPs provided performance feedback. 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, psychology staff were beginning to collect IOA in eight homes. IOA collection included both target and replacement behaviors, and the methodology was continuing to be developed. The monitoring team was encouraged by the development of IOA at MSSLC. It is recommended that the facility continue to expand the sites (i.e., all homes and day/vocational sites) in which IOA is collected. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those levels. Another area of continued improvement was the 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 #367's functional assessment included recording and graphing noncompliance by hour, to better understand the variables that affected this target behavior. • Individual #126's suicide threats were graphed in daily increments to better understand if this behavior was more likely to occur on some days compared with others.	

#	Provision	Assessment of Status	Compliance
		Although improved, the monitoring team believes that the graphs at MSSLC could be easier for staff to interpret (and therefore use) by utilizing a more simplified presentation. At the time of the onsite review, the majority of graphs reviewed utilized multiple data paths resulting in graphs that were confusing to understand, which would potentially discourage their use. One reason there were so many data paths on each graph was that each individual's medications were graphed along with his or her target behaviors. It is recommended that only target and replacement behaviors be included in each graph. The effects of medication changes (and other potentially important environmental events such as moves to different residences) could be displayed by the use of phase lines or arrows, thereby allowing the reader to quickly evaluate the effectiveness of these changes on each individual's behavior. Although the monitoring team was encouraged by the use of more flexible data systems at MSSLC, the routine use of data to make treatment decisions was not apparent in observations during the onsite review. For example: • In Individual 466's psychiatric clinic observed, target behaviors were only graphed and presented up to the previous month. The last three weeks of data were not graphed. Up to date graphed data is a very important for ensuring data-based medication decisions. • In Individual 74's psychiatric clinic, no graphed data were presented. 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 12 individuals, five (42%) (Individual #209, Individual #502, Individual #54, Individual #491 and individual #469) indicated improvement in severe behavior (e.g., aggression or self-injurious behavior). This represented a slight decrease from the last onsite review when 60% of the plans reviewed suggested improvements in dangerous behaviors. Additionally, there was some indication that when progress was not occurring, action to address the lack of progress was occurring. For example, the list of PBSPs indicated that Individual #401's PBSP was modified prior to the annual review due to the absence of progress. 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	

#	Provision	Assessment of Status	Compliance
		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 full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of initial (full) psychological assessments for each individual, the absence of functional assessments for each individual with a PBSP, and the lack of comprehensiveness of some of these assessments. <u>Psychological Assessments</u> As noted in previous reports, 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 276 of the 390 individuals at MSSLC (71%) had an initial psychological assessment. This represented an improvement from the last review when 61% of individuals had initial psychological assessments. Eleven of the 29 initial psychological assessments completed since the last review (38%) were reviewed to assess compliance with this provision item: • Eight (Individual #514, Individual #87, Individual #63, Individual #491, Individual #504, Individual #350, Individual #325, and Individual #51) of 11 initial psychological assessments reviewed (73%) 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. This represents an improvement from the last review when only 25% of initial assessments reviewed were complete. • Three initial assessments (Individual #279, Individual #494, and Individual #342) 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Functional Assessments 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 indicated that eight were completed since the last review. All eight of these functional assessments (100%) were reviewed to assess compliance with this item of the Settlement Agreement. Two of the functional assessments reviewed indicated that target behaviors did not occur in the past 12 months (Individual #479 and Individual #388) and, in one (Individual #279), target behaviors did not occur since the individual resided in his current home. These functional assessments included all of the necessary components, however, since the behaviors occurred at such a low rate, these assessments could not be evaluated for content and, therefore, were not included in the following review. As found in the last report, the remaining five 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 as they could be. Ideally, all functional assessments should include direct and indirect assessment procedures. A direct observation procedure consists of direct and repeated 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 procedures can contribute to understanding why a target behavior occurred by conducting/administrating questionnaires, interviews, or rating scales. All five of the functional assessments reviewed included acceptable direct and indirect procedures. This represented a considerable improvement in the number of complete direct assessment procedures compared to the September 2011 review when only 22% of direct observation procedures were judged to be acceptable. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This is consistent with the last report when all functional assessments included 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. One of the five	

#	Provision	Assessment of Status	Compliance
		functional assessments reviewed (20%) did not include a summary statement (i.e., Individual #126). This represented another improvement from the last review when 44% of the functional assessments reviewed did not have a clear summary statement. The following represents a particularly good example of a summary statement: • Individual #143's functional assessment included a summary statement with a clear hypothesis that Individual #143's undesired behaviors were maintained by automatic functions. The summary statement went on to identify specific antecedent events hypothesized to occasion her target behaviors. 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. Individual #401 and Individual #143's functional assessments indicated that they were revised at least once since they were originally written. 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). Four (Individual #401, Individual #199, Individual #143, and Individual #367) of the five functional assessments reviewed (80%) were evaluated to be comprehensive and clear. This represented a significant improvement over the last report when only 11% of the functional assessments reviewed were evaluated as acceptable. The monitoring team was very pleased with the progress MSSLC was making in the quality of functional assessments. It is recommended that the facility now develop a plan to ensure that all individuals with a PBSP have a current functional assessment.	
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) or current, 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 103 of the 276 (37%) were not conducted in the last five years. This represents an improvement over the last report when 52% of intellectual assessments were more than five years old. Psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 18 of the 390 of the individuals at MSSLC (5%). This represented a slight decrease from the last review when 7% of individuals had annual psychological assessments. One annual review was completed since the last review and it was reviewed by monitoring team to assess its comprehensiveness: • Individual #71's annual psychological assessment was complete and contained a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and 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 complete annual psychological assessments. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of a recent admission (Individual #87) to the facility indicated that this component of this provision item continued to be in substantial compliance.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	Psychological services, other than PBSPs, were provided at MSSLC. This was another area where the facility has continued to make good progress. In order to attain substantial compliance, however, the facility needs to ensure that there is an individualized fail criterion and a plan for generalization in each treatment plan. 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-one individuals were receiving group therapy and 14 were receiving individual counseling 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, and/or PBSPs, and in the treatment plan. Additionally, the therapies appeared to be conducted by qualified staff.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The monitoring team observed an anger management group session. The group appeared to be very well organized and had clear objectives for the session. After 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). The monitoring team also reviewed 23 of the 175 treatment plans (13%) to determine compliance with this provision item. The treatment plans contained documentation of services that were goal directed with measurable objectives and treatment expectations. Additionally, each treatment plan included a fail criterion, and a statement concerning generalization. The fail criteria and plan for generalization were, however, identical for each individual. For example Individual #195's STARS treatment plan included, "Individual #195's attendance and SPO will be reviewed at least quarterly. If there is an increase in the number of absences or lack of progress for three consecutive months, the facilitator will review the SPO with the PST." The fail criteria of each treatment plan should be individualized, and include specific events (e.g., 20% increase in physical aggression) that would trigger a review, revision, or termination of therapy. Additionally, the statements addressing generalization were also very generic sounding and did not clearly include procedures for increasing generalization. For example, Individual #195's treatment plan included, "To determine generalization of skills into daily living, instances of Rage Reaction will be reviewed to determine progress or regression." Finally, the monitoring team was not provided any progress notes. It is recommended that all treatment plans contain individualized fail criteria, and clear procedures for generalizing skills learned or intervention techniques to living, work, leisure, and other settings. Additionally, all therapy sessions should include documentation and review of progress. Even though this provision item was rated as being in noncompliance, the monitoring team acknowledges, and is encouraged by, the efforts of the psychology department towards achieving substantial compliance with this provision item.	
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	This item was rated as being in noncompliance because not all PBSPs reviewed contained interventions that were based on functional assessment results. A list of individuals with PBSPs indicated that 297 individuals at MSSLC had PBSPs, and 127 of these were completed since the last review. Fourteen (11%) of these 127 PBSPs were reviewed to evaluate compliance with this provision item. All 14 of the PBSPs reviewed had the necessary consent and approvals. All PBSPs reviewed included descriptions of target behaviors, and all of these were	Noncompliance

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	as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	operational (100%). This represented a sharp improvement in operational definitions from the last report when only 60% of the target behaviors were operationally defined. All 14 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but three (i.e., Individual #570, Individual #202, and Individual #65) of these (23%) identified antecedents and/or consequences that appeared to be inconsistent with the stated function of the behavior and, therefore, were not likely to be useful for weakening undesired behavior. This represented an improvement in the effectiveness of antecedent and consequent procedures relative to the last report when 27% were judged to be inconsistent with the stated function. An example of a consequent intervention potentially incompatible with the hypothesized function was: • Individual #65's PBSP hypothesized that his physical aggression was maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). His PBSP, however, included asking him to walk to another area following physical aggression. If avoiding undesired activities was reinforcing for Individual #65, then this intervention would likely increase the likelihood of his disruptive behavior. Ideally, after the targeted behavior occurred, Individual #65 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of his undesired behavior is such that it is dangerous to maintain him in the activity, 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 (i.e., replacement behavior). The PBSP needs to clearly state that removal of the undesired activity should be avoided whenever possible, because it encourages future undesired behavior. 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 #360's PBSP hypothesized that his aggressive behavior functioned to gain other people's attention. Antecedent interventions included providing him with staff attention when he was exhibiting appropriate behaviors, and encouraging/reinforcing him for engaging in his replacement behavior (i.e., talking to staff about what is upsetting him) when he began to get upset. His intervention following aggression included directing him to a time-out area where attention was minimized. 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.	

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		As in the last report, replacement behaviors were included in all of 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 reinforcer for alternative behavior is practical. The monitoring team found that replacement behaviors were not functional in two (i.e., Individual #575 and Individual #65) of the eight (25%) PBSPs with replacement behaviors that could be functional. This represented another improvement from the last report, when 30% of all replacement behaviors that could be functional were not functional. An example of a replacement behavior that was not functional was: • Individual #575's PBSP hypothesized that his undesired behaviors were maintained by negative reinforcement. His replacement behavior was participating in programming as scheduled. These behaviors were incompatible with his target behavior and, therefore, likely an appropriate goal for Individual #575, however, it did not appear to be functional. An example of a functional replacement behavior could include teaching/reinforcing another way to escape or avoid unpleasant activities, such as asking for a break. All eight of functional replacement behaviors discussed above appeared to be behaviors already in the individual's repertoire and, therefore, the PBSP instructions were more related to actions staff needed to complete rather than skills the individual needed to acquire. For replacement behaviors that are already in the individual's repertoire, a SAP would not be required. For example • Individual #502's replacement behavior was telling staff when he wanted to leave an area. The PBSP included instructions for staff to encourage Individual #502 to express his desires, and to accommodate him when possible. Overall, nine (Individual #572, Individual #209, Individual #502, Individual #360, Individual #54, Individual #519, Individual #491, Individual #469, and Individual #367) of the 14 PBSPs reviewed (64%) represented examples of complete plans that contained operational definitions of target behaviors, functional replacement behaviors (when possible and practical), and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented an improvement over the last review when 47% of the PBSPs reviewed were judged to be acceptable.	
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	The monitoring team was encouraged by the initiation of the collection of IOA measures at MSSLC (see K4). In order to achieve substantial compliance with this provision item, a system to regularly assess, track, and maintain minimum levels of agreement of PBSP data (i.e., IOA) across the entire facility will need to be demonstrated.	Noncompliance

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	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.	Target and replacement behaviors were consistently graphed monthly at MSSLC. As discussed in K4, the quality and usefulness of many of these graphs had improved, however, it is recommended that they be simplified by indicating event changes (e.g., medication changes) with phase lines rather than multiple data paths. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	MSSLC continued to make improvements toward simplifying PBSPs and, therefore, increasing the likelihood that PBSPs will be understood and implemented as written by DCPs. This provision item was rated as being in noncompliance, however, 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, to ensure they could be understood by DCPs. The self-assessment indicated the average reading level of PBSPs at the facility was 9.62. This process of monitoring and reducing the reading level of PBSPs will likely result in more practical and useful plans 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 PBSPs. Direct observation is an essential component of treatment integrity and achieving substantial compliance with this item. There were, however, no integrity data available for review during the onsite review. The monitoring team looks forward to reviewing integrity data during future onsite reviews.	Noncompliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete	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 (see K11). Although improving, more work in this area is needed to achieve substantial compliance with this item.	Noncompliance

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	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.	The self-assessment indicated that not all staff assigned to work with individuals were trained on their PBSPs. 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.	
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 390 individuals and employed 14 psychologists responsible for writing PBSPs. Additionally, the facility employed nine psychology assistants and six psychology technicians. One of the facility's 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 that write PBSPs either possess a BCBA, or are enrolled in coursework to attain their BCBA (K1).
2. The facility should initiate data collection reliability for all target and replacement behaviors collected in each residence and day/vocational site. Finally, specific reliability goals should be established, and staff retrained or data systems modified, if scores fall below those goals (K4).
3. It is recommended that the facility continue to expand the sites (i.e., all homes and day/vocational sites) that IOA is collected. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals (K4, K10).
4. Data should be graphed in increments that allow data based treatment decisions. Additionally, the graphs should be consistently available when treatment/medication decisions are made (K4, K10).
5. The graphs should be simplified. It is recommended that only target and replacement behaviors be included in each graph. The effects of medication changes (and other potentially important environmental events such as moves to different residences) could be displayed by the use of phase lines or arrows, thereby allowing the reader to quickly evaluate the effectiveness of these changes on each individual's behavior (K4, K10).
6. Ensure that all treatment decisions are data based (K4).

7. Ensure that some action (e.g., modification of the PBSP, retraining of staff, additional functional assessment, etc.) had occurred for any individual not making expected progress (K4).

8. 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).

9. All individuals with a PBSP should have a functional assessment (K5).

10. 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).

11. A revision of the functional assessment should be completed when new information is learned concerning the variables affecting an individual's target behaviors (with a maximum of one year between reviews) (K5).

12. The facility should develop a plan to ensure that all individuals with a PBSP have a current functional assessment (K5).

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

14. All individuals at should have annual psychological assessments (K7).

15. Ensure that all psychological services (other than PBSPs) include:
    - A treatment plan that includes an initial analysis of problem or intervention target
    - Services that are goal directed with measurable objectives and treatment expectations
    - Services that reflect evidence-based practices
    - Services that include documentation and review of progress
    - A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention
    - A service plan that includes procedures to generalize skills or intervention techniques to living, work, leisure, and other settings (K8).

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 should be functional (i.e., should represent desired behaviors that serve the same function as the undesired behavior) when possible (K9).

18. An effective treatment integrity system should be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established (K11).

19. The facility needs to provide documentation that all staff assigned to work with an individual have 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 Preventive Health Care Guidelines, 8/30/11 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 Seizure Management, 2/15/12 o MSSLC Self-Assessment, o Presentation Book for Section L o MSSLC Organizational Charts o MSSSLC Nursing Protocol: Seizure Management Guidelines, 2/11 o DADS Clinical Guidelines: • Aspiration Risk Reduction Interdisciplinary Protocol • Enteral Feedings Interdisciplinary Protocol • Constipation/Bowel Management • Constipation Interdisciplinary Protocol • Urinary Tract Infections • Assessment and Management of Urinary Tract Infections for DSPs • Assessment and Management of Urinary Tract Infections for Nurses • Seizure Management Interdisciplinary Protocol • Seizure Management Instruction for the PCP • Seizure Management Instruction for DSP • Seizure Management Instruction for Nurse • Diabetes Mellitus • Osteoporosis 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 and internal medical reviews conducted in November 2011 and March 2012 o Listing of medical staff

	o Medical Caseload Data o Mortality Review Documents o Daily Clinical Services Meeting Notes, o Medical Review Committee Meeting Notes, 12/14/11, 12/29/11, 1/5/12 o Infection Control Committee Meeting Minutes, o Pneumonia Review Logs o Consultation Tracking Logs o Onsite Clinic Schedule 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 ISPs, and ISP addendums for the following individuals: • Individual #109, Individual #304, Individual #600, Individual #29, Individual #65, Individual #229, Individual #266, Individual #542, Individual #518, Individual #32 o Neurology Notes for the following individuals: • Individual #31, Individual #456, Individual #361, Individual #533, Individual #474, Individual #369, Individual #511, Individual #29, Individual #600, Individual #188, Individual #29 o Annual Medical Assessments for the following individuals: • Individual #177, Individual #105, Individual #17, Individual #279, Individual #571, Individual #462, Individual #170, Individual #325, Individual #6, Individual #215, Individual #43, Individual #248, Individual #285, Individual #249 o Consultation Referrals, IPNs and Physician Orders for the following individuals: • Individual #177, Individual #105, Individual #17, Individual #279, Individual #571, Individual #462, Individual #170, Individual #325, Individual #6, Individual #215, Individual #43, Individual #248, Individual #285, Individual #249 <u>Interviews and Meetings Held</u>: o Dolores Erfe, MD, Medical Director o Christopher Ellis, MD, Primary Care Physician o James Gilley, Primary Care Physician o Yong Chin, MD, Primary Care Physician o Scott Davis MD, Primary Care Physician o William E. Thomas, Physician Assistant o Kendall Brown, MD, Lead Psychiatrist o Juanita Kirby, MD, Psychiatrist o Angela Johnson, RN, Medical Compliance Nurse o Norris Buchmeyer, RN, Chief Nursing Executive o Karen Wilson RN, QA Nurse

	o Dawn Price, RN, QA Nurse <u>Observations Conducted</u>: o Opening Meeting o Daily Clinical Services Meetings o Medical Review Committee Meeting o PET II Meeting o Informal observations of cottages and day services areas o ISP Meeting for Individual #597
	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan and (3) a list of completed actions. For the self-assessment, the facility described for each of the four provision items, a series of activities engaged in to conduct the self -assessment, the results of the self-assessment and a self-rating. This was a great improvement in the assessment process. During the week of the onsite review, the monitoring team made an effort to ensure that staff understood the self-assessment process and had an opportunity to ask questions. Most appeared eager to understand and realized that the process was valuable in helping the facility to move towards substantial compliance. To take this process forward, the monitoring team recommends that the medical director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility rated itself in noncompliance with provisions L1, L3, and L4. It rated itself in substantial compliance with provision L2. The monitoring team found noncompliance for all four provision items.
	Summary of Monitor's Assessment: This review demonstrated that some progress was made in the provision of medical services. This was primarily noted in the actions of the medical staff. The monitoring team noted during observations of IDT meetings, the Medical Review Committee meeting, and numerous other interactions that several medical providers supported individuals in a manner that afforded the individuals an opportunity to have the best health possible. The facility should be encouraged by this finding. This was supported by the detail of the

	discussions, the approach to the problems, and the documentation contained in the records. Notwithstanding this encouraging finding, the monitoring team could not ignore that the medical department continued to struggle in several areas. Several records indicated that preventive services, such as colonoscopies were not provided and that issue needs to be addressed. Overall, the facility will need to ensure that it is appropriately providing the necessary cancer screenings and has the IT framework to accurately track the required data elements. More progress was expected at this review. The etiology of the lack of progress was not clear. There were some good clinicians who were observed at work. Many actions that should have occurred did not occur. There was no facility policy developed for the state issued preventive care policy, and the preventive care flowsheet had not been implemented. There had been no quality initiatives undertaken at the facility level. The mortality system was rather dysfunctional and members of the Clinical Death Review Committee could not demonstrate implementation of their very own recommendations. Finally, data integrity was problematic. There were marked discrepancies noted in the numbers for this review in comparison to the September 2011 review for several of the preventive care listings. It appeared that when a request for a list of <u>all</u> individuals over a certain age was made, the facility imposed a cutoff age rather than include all individuals and provide explanations when preventive care services were not provided. This was done without any notation or explanation to the monitoring team and is an unacceptable approach for data submission. There were numerous other problems related to information submitted. Mammogram and colonoscopy data were listed as completed when that was not the case. The data were incorrectly represented and only detected as incorrect through record reviews. Accuracy could only be validated in those instances in which the monitoring team completed a record review. The accuracy of all information contained in the medical databases must be examined. The monitoring team noted several instances of grossly inaccurate data regarding several areas including osteoporosis care and seizure outcome data. It will be important for the facility to understand the importance of data integrity and management.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by	The 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. **Staffing** The medical staff was comprised of a full time medical director, three locum tenens physicians, one staff physician, and one physician assistant. The average caseload was	Noncompliance

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	the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	78 with the largest being 95. A medical program compliance nurse, who was hired in December 2011, reported directly to the medical director. The medical director did not have primary responsibility for medical care, but was responsible for supervision of the physician assistant. An adequate agreement was in place between the physician assistant and the medical director. Although not included in the staffing roster, it was reported that the respiratory therapist was under the supervision of the medical department. The medical director acknowledged that this was a recent change and she had not yet addressed the position in terms of job duties and responsibilities. **Physician Participation In Team Process** The facility continued the daily 8:30 am clinical services meetings that were implemented in September 2011. The medical director facilitated these meetings which were attended by the medical staff, multiple department heads, and other key staff. The monitoring team attended several of these meetings and observed that the process provided a collaborative means of reviewing events that occurred over the previous 24 hours. The meeting was brief, lasting approximately 30 minutes. The primary providers were able to conduct medical clinics following completion of this meeting. **Overview of the Provision of Medical Services** Medical care was provided in a clinic format. Each unit had a clinic where individuals were taken to see their physician. A calendar was maintained in each home to record those needed to be seen. The individuals received a variety of medical services. They were provided with preventive, routine, specialty, and acute care services. The facility continued to conduct onsite dental and podiatry clinics. Dental clinic was conducted daily. Podiatry clinic occurred twice a month for half a day. In late February 2012, a monthly neurology clinic began being conducted onsite. The neurologist was available the entire day. Other specialty services were usually provided at Scott and White Medical Center. Individuals who required acute care were transferred to local hospitals. When admission was necessary, the individuals were admitted to the on-call MD. The facility maintained a hospital liaison program through nursing services. 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. Radiographs were done onsite and digital images were available immediately. 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 provision of care varied among providers. Even so, the monitoring team noted that most did an adequate job. There were examples of very good care and there were examples of care that required improvement. The various sections of this report will	

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		provide examples of both the high and low points noted during this review. **Documentation of Care** The Settlement Agreement sets forth specific requirements for documentation of care. The monitoring team reviewed numerous routine and scheduled assessments as well as record documentation. The findings are discussed below. Examples are provided in the various subsections and in the end of this section under case examples. <u>Annual Medical Assessments</u> For the Annual Medical Assessments included in the record sample: • 9 of 10 (90%) AMAs were completed in a timely manner • 8 of 10 (80%) AMAs included comments on family history • 8 of 10 (80%) AMAs included information about smoking and/or substance abuse history For the sample of Annual Medical Assessments submitted by the facility: • 15 of 15 (100%) AMAs were completed in a timely manner. • 13 of 15 (87%) AMAs included comments on family history • 13 of 15 (87%) AMAs included information about smoking and/or substance abuse history Overall, the quality of the annual medical assessments improved. The format of the documents reviewed was standardized and included a history of present illness, current diagnoses, past medical/surgical history, current medications, family and social histories, immunizations, physical exam, assessment, and plan of care. Notwithstanding these improvements, the history of present illness was excessively brief in several assessments and failed to provide an adequate explanation of the events of the past year. Many of the annual assessments did not adequately address the preventive care issues, such as colorectal, breast, cervical, and prostate cancer screening. When those studies where not completed, there frequently was no explanation provided for a lack of completion. The plans of care for the active problems were sometimes inadequate and many assessments continued to present problems in a manner that failed to link related problems. <u>Active Problem List</u> Significant improvement was noted in the updating of the Active Problem Lists. All of the documents reviewed were dated. For the records contained in the record sample: • 10 of 10 (100%) records included APLs that were updated	

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		The additions were not always dated and there were some APLs that omitted a diagnosis. Overall, documentation in this area was greatly improved. Individual #65 had iron deficiency anemia omitted form the APL. <u>Quarterly Medical Summaries</u> Improvement was noted in the completion of Quarterly Medical Summaries. The format of the summaries differed among the providers. All of the documents included a minimum of an interval summary, a list of medications, and the active diagnosis. For the records contained in the record sample: • 10 of 10 (100%) records included at least one Quarterly Medical Summaries • 4 of 10 (40%) records included at least two consecutive Quarterly Medical Summaries The quality of the summaries varied among providers. Some records contained summaries that were very detailed and provided excellent interval accounts of the events of the quarter including all labs and diagnostics. <u>Integrated Progress Notes</u> Physicians documented in the IPN in SOAP format. The notes were usually signed, dated, and timed. Pre-hospital and post-hospital notes were usually written. Documentation of follow-up care was sometimes lacking. <u>Physician Orders</u> Physician orders were usually signed and dated. There were some entries that were not timed, but this appeared to be a very practitioner-specific pattern. Incomplete orders or orders that required clarification or correction of dosages, routes, and stop dates were encountered, but again this was very practitioner-specific. <u>Consultation Referrals</u> The consultation referral forms usually included the information needed for completion of the consultation. For the most part, the records in the sample indicated significant improvement in the documentation of consults in the IPN. For the consultation reports contained in the record sample, a total of 18 consults completed over the past six months were reviewed and the findings are summarized below:	

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		• 14 of 18 (77%) consultations were summarized by the medical providers in the IPN • 12 of 14 (86%) were documented within five working days. For the sample of consultation reports submitted with the document request, 28 consultations completed in the last six months were reviewed: • 25 of 28 (90%) consultations were summarized by the medical providers in the IPN • 19 of 25 (76%) were documented within five working days Individual #514 had multiple medical consults that lacked IPN physician entries. **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. Documentation indicated that the yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals, but documentation of varicella status remained inconsistent and difficult to find. There were a few individuals who received the Hepatitis B vaccination whose immune status remained unclear. • Individual #600 had a diagnosis of diabetes mellitus but did not receive the pneumococcal vaccination. This individual also lacked antibodies to the Hepatitis B surface antigen. The individual had completed the hepatitis B series vaccination and the medical provider indicated that a booster would be administered. The medical provider should review the records of this new admission and determine if revaccination or a booster vaccination is appropriate. • Individual #32 received the hepatitis vaccination but did not appear to have immunity. • Individual #62 did not have clear documentation regarding hepatitis B immune status. The state issued preventive care services policy was implemented, but there was no development of a facility policy as required by state office, and the new Preventive Care Flowsheet had not been implemented. The current flowsheet provided limited immunization documentation and was overall not consistent with current guidelines. Databases were developed to track preventive care services, such as cancer screenings and osteoporosis. The medical department also maintained a seizure database. The immunization database was maintained by the nursing department. Data from the 10 record reviews listed above and the facility's preventive care reports are summarized	

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		below. It should be noted that for several of the listings, the facility elected to make an arbitrary, but undisclosed, cutoff point for the listings, so the compliance percentages will be significantly higher than those reported in the September 2011 report: <u>Immunizations</u> • 10 of 10 (100%) individuals received the influenza and hepatitis B vaccinations • 8 of 10 (80%) individuals received the pneumococcal vaccinations <u>Screenings</u> • 9 of 10 (90%) individuals received appropriate vision screening • 9 of 10 (90%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 1 of 4 males met criteria for PSA testing • 0 of 1 (0%) males had appropriate PSA testing A list of males greater than 50 was provided. The list contained 74 individuals: • 64 of 74 (86%) males had PSA results documented within in 2011 or 2012 o 7 of 64 (11%) were due in January 2012 o 10 of 64 (16%) were due in February 2012 • 10 of 74 (14%) had PSA results documented for 2010 <u>Breast Cancer Screening</u> • 5 of 6 females met criteria for breast cancer screening • 3 of 5 (60%) females had current breast cancer screenings A list of females age 40 and older was provided. The list contained the names of 54 females, the date of screening, and explanations for lack of testing: • 48 of 54 (89%) females completed mammography in 2010 or 2011 • 5 of 54 (9%) females completed mammography in 2009 • 1 of 54 (2%) females completed mammography in 2008 <u>Cervical Cancer Screening</u> • 5 of 6 females met criteria for cervical cancer screening • 4 of 5 (80%) females completed cervical cancer screening within 3 years • 1 of 5 (20%) females had completed cervical cancer screening in 2009 A list of females age 18 and older was provided. The list contained the names of 63 females, the date of the last pap smear, and explanations for lack of testing:	

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		• 17 of 63 (27%) females completed cervical cancer screening in 2011 or 2012
		• 15 of 63 (24%) females completed cervical cancer screening in 2010
		• 20 of 63 (32%) completed cervical cancer screening in 2009
		• 11 of 63 (17%) females completed screening prior to 2009
		
		<u>Colorectal Cancer Screening</u>
		• 6 of 10 individuals met criteria for colorectal cancer screening
		• 0 of 6 (0%) individuals had undergone colonoscopy for colorectal cancer screening
		
		A list of individual's age 50 and older was provided. The list contained 127 individuals:
		• 75 of 127 (59%) individuals had completed colonoscopies
		• 52 of 127 (41%) individuals did not have documentation of colonoscopy
		  o 25 of 52 (48%) had no reason documented
		  o 21 of 52 (40%) were pending
		  o 3 of 52 (6%) were refusals
		  o 2 of 52 (4%) were other, such as hospice and colectomy
		• 1 of 52 (2%) of individuals had completed a colonoscopy more than 10 years ago
		
		This list appeared to include colonoscopies that were scheduled in the future as having been completed. Some of those were verified as not having been done through record audits. The accuracy of these data was not known to the monitoring team.
		
		Medical Management
		State office issued numerous multidisciplinary clinical guidelines. The monitoring team reviewed records and facility documents to assess overall care provided for osteoporosis, GERD, diabetes mellitus, and pneumonia. Data derived from record audits and the facility reports are summarized below.
		
		<u>Diabetes Mellitus</u>
		Two records were reviewed for compliance with standards set by the American Diabetes Association: (1) glycemic control (HbA1c<7), (2) monitoring for diabetic nephropathy (3) annual eye examinations, and (4) administration of yearly influenza vaccination:
		• 2 of 2 (100%) individuals had adequate glycemic control
		• 0 of 2 (0%) individuals had urine microalbumin documented
		  o 1 individual was a newly diagnosed diabetic
		• 2 of 2 (100%) individuals had eye examinations in 2011
		• 2 of (100%) individuals received the yearly influenza examination	

#	Provision	Assessment of Status	Compliance
		Osteoporosis The following information was obtained from the review of the record sample: • 7 of 10 individuals were diagnosed with osteoporosis • 7 of 7 (100%) individuals received calcium and vitamin D supplementation • 7 of 7 (100%) individuals had vitamin D levels monitored • 7 of 7 (100%) individuals received treatment with Alendronate or Reclast • 7 of 7 (100%) individuals had appropriate monitoring of bone mineral density A list of 90 individuals with the diagnosis of osteoporosis or osteopenia was provided. A comparison of the list to the information noted in record reviews showed discrepancies in medication regimens for all individuals included in the record audits. No further analysis of this information was done. Discrepancies included: • Individual #266 was not on the facility list. This individual was diagnosed with osteoporosis and was treated with calcium and vitamin D supplementation in addition to receiving Reclast. • Individual #518 was diagnosed with osteoporosis and was not on the list. Treatment provided included calcium, vitamin D supplementation, and Reclast. The September 2011 report highlighted the inaccuracy of osteoporosis data due to the use of the pharmacy drug report as a means of generating information on management of osteoporosis and osteopenia. The monitoring team recognized that the use of Reclast was added to the APL and that was good to see. That addition, however, would not assist the medical director in any review of the quality of osteoporosis care. If the medical director reviewed the data provided to the monitoring team, the assessment of osteoporosis management would be incorrect. The monitoring team would like to emphasize that data should be maintained for use in ensuring that individuals receive appropriate treatment. That goal cannot be accomplished with the use of incomplete or inaccurate data. GERD The following information was obtained from the review of the record sample: • 3 of 10 individuals were diagnosed with GERD • 3 of 3 (100%) individuals received appropriate treatments with a PPIs • 3 of 3 (100%) individuals had additional non-pharmacologic supports in place	

#	Provision	Assessment of Status	Compliance
		Pneumonia The facility submitted a list of persons with the diagnosis of pneumonia over the past 12 months. The list contained 27 individuals with 36 episodes of pneumonia. The medical director reported that following the last review, a pneumonia review process was implemented to review all cases of pneumonia and this was discussed at the Medical Review Committee meeting. The tracking logs submitted to the monitoring team were reviewed. For the months of November 2011 and February 2012, the logs appeared complete. There were no entries into the January 2012 log and December 2011 had only one entry. There were eight cases of pneumonia during those two months. In those cases where the logs were completed, it appeared that good information was being noted, including dates of hospitalization, x-ray findings, lab results, culture results, use of enteral nutrition, presence of diagnoses such as GERD and dysphagia, and medications. The hospital liaison nurse originally reported that this information was discussed at the nursing management meetings. There was no documentation of this and it was later clarified that the discussions would begin occurring in the future. It also appeared that this information was not regularly discussed at the Medical Review Committee meetings and when it was discussed, there was a significant delay from the occurrence of the hospitalization to the time of discussion. The next step in this process would be to ensure that interventions are appropriate. The monitoring team highly encourages that, in addition to maximizing special supports, consideration be given to development of guidelines for management of individuals with recurrent aspiration. These guidelines should include the full armamentarium of diagnostic and therapeutic modalities including, but not limited to, fundoplication, small bowel feedings, assessment for salivary aspiration, and reduction of salivation. With development of guidelines, it is critical that an adequate risk/benefit analysis be completed and appropriate specialty consultations occur, so that guidelines are applied to those who might benefit from these interventions. This would mean that an individual who received enteral nutrition through a gastric tube, and had evidence of aspiration, had the appropriate assessments and interventions. The complicated nature of management of aspiration and aspiration pneumonia demands that efforts be multidisciplinary. The review of the pneumonia cases should be multidisciplinary and involve medical, nursing, habilitation, respiratory, and nutritional services. The current reviews laid the groundwork for such a process.	

#	Provision	Assessment of Status	Compliance
		Case Examples Individual #518 • The annual assessment did not include the required smoking and family history. • QMSs dated 8/29/11 and 12/5/11. • The APL did not include the diagnosis of constipation although the individual received multiple medications. • The indication for Haldol and lorazepam was "prevention of pulling tube out," but individual was not followed by psychiatry. • The AMA was done six months prior to the ISP. • There was no documentation of a proper foot exam or urine microalbumin for the diagnosis of diabetes. • There was no explanation for the lack of a colonoscopy. • Pre-hospital transfer note dated 5/16/11; hospital discharge note, undated, did not include a physical exam after a month hospital stay. Individual #32 • The annual assessment documented the smoking history. • The QMS was dated 3/19/11. The 9/20/11 QMS was not located in record. • The individual was listed as having completed a colonoscopy on 2/21/12, but the records did not reflect that a colonoscopy was completed on that date. • There were multiple external medical consultations that occurred which were not documented in the IPN. • PSA testing was not completed in accordance with facility guidelines. • The APL excluded the diagnosis of hyperlipidemia and listed osteopenia instead of osteoporosis. • Pre-hospital transfer note dated 11/4/11 and hospital discharge note dated 11/10/11. Both were present as required. • Following hospitalization in November 2011, documentation of physician follow-up was inconsistent. Individual #266 • The annual assessment lacked the required smoking and family history. • This was a post-menopausal female with "iron deficiency per chart." Labs indicated a ferritin level of 9.5 on 8/8/11. The etiology of the iron deficiency had not been identified. The individual received supplementation with iron, but not evaluated for GI blood loss. The AMA did not address this problem. • There was no pre-hospital transfer note on 10/29/11, since the PCP was not onsite. There was a hospital discharge note on 11/17/11. • Numerous clinical encounters were not documented in SOAP format.	

#	Provision	Assessment of Status	Compliance
		Seizure Management Individuals with the diagnosis of seizure disorder were seen at Scott and White medical center. In recent months, the facility began conducting an onsite neurology clinic as well. This was intended to improve integration with psychiatry, but the psychiatrists did not attend neurology clinic. A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 107 individuals with a diagnosis of seizure disorder. Nine individuals were documented to have refractory seizure disorder, one of whom had a VNS implant. Two individuals required transport to acute care facilities for prolonged seizures. The record requests indicated that no individuals experienced status epilepticus since the last visit. The records of Individual #62 and Individual #266 documented a history of status since the last onsite review. The seizure database maintained by the medical department provided information on the medications received by individuals for management of seizure disorders: • 5 of 107 (4%) received 0 AEDs • 58 of 107 (54%) received 1 AEDs • 26 of 107 (24%) received 2 AEDs • 12 of 107 (11%) received 3 AEDs • 6 of 107 (7%) received 4 AEDs • 0 of 107 (0%) received 5 AEDs • 37 of 107 (35%) of individuals received the older more toxic drugs The number of individuals seen in the on-campus clinic and by the epileptologist is summarized in the table. Neurology Clinic Appointments 2011 - 2012 | | On-Campus | Community | | Sept | -- | 10 | | Oct | -- | 16 | | Nov | -- | 12 | | Dec | -- | 15 | | Jan | -- | 6 | | Feb | 4 | 8 | | Total | 4 | 67 | A total of 71 visits occurred during the months of September 2011 through February 2012. The facility supported 107 individuals with a diagnosis of seizure disorder. This would appear to be a reasonable number of clinic visits if all individuals with an active seizure disorder were seen one to two times per year.	

#	Provision	Assessment of Status	Compliance
		The facility submitted neurology consultation notes documenting seizure management for 10 individuals. These individuals are listed in the documents reviewed section. The following provides a summary of the review of these records: • 5 of 10 (50%) individuals were seen at least twice over the past 12 months • 8 of 10 (80 %) notes included a review of current medications for seizures and dosages • 5 of 10 (50%) notes included recent blood levels of antiepileptic medications. • 0 of 10 (0%) notes referenced the presence or absence of side effects, including side effects from relevant side effect monitoring forms. • 9 of 10 (90%) notes included recommendations for medications • 0 of 10 (0%) notes included recommendations related to monitoring of bone health, etc. The medical director developed a template for use in neurology clinic, but that template and the content of the template did not appear to be used. The facility should certainly have control over the content of the notes generated at the onsite clinic. Clinic notes again indicated that labs and seizure logs were not provided. The medical director should investigate why this occurred. For individuals who are seen only once or twice a year it is important that the clinic notes provide adequate documentation of seizure management including drug dosages, severity of seizures, date of last seizure, results of drug monitoring, and the impact of the seizure disorder and AEDs on the quality of life. The monitoring team made some additional observations regarding the overall seizure management program at the facility. A list of nine individuals with the diagnosis of refractory seizure disorder. One of the nine individuals had undergone VNS implantation in recent months. The others were stated to be in the "early" stages of evaluation for VNS placement. Neurology notes reviewed for Individual #533 and Individual #29 indicated that seizure management was difficult and refractory. Both received medical management and there was no documentation that either was being considered for VNS implantation. **Do Not Resuscitate** The monitoring team requested a list of persons with current DNRs, reason/criteria for DNR, implementation dates, notes, and orders for DNRs. The facility submitted a list of two persons with current DNR orders. The orders and full explanations were not provided.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Individual #432 had a DNR order implemented on 11/16/11. Failure to thrive was listed as the reason. The criteria were cited as originated by off campus physician and hospice. No further information was provided.
• Individual #120 had DNR order implemented on 12/1/11 due to guardian request. The facility provided no medical reason or rational for the decision.

The monitoring team is not able to provide any comments on the appropriateness of the implementation of these DNRs without the benefit of review of additional information. The facility must ensure that current state policy is followed.</td><td></td></tr>
<tr><td>L2</td><td>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.</td><td><u>Medical Reviews</u>
External medical reviewers, from sister SSLCs, conducted medical reviews in November 2011 and March 2012. 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 to be in place, in addition to receiving a score of 80% on nonessential items. Data for individual provider performance were provided. Aggregate data are presented in the table below. Compliance scores represent the average scores for the five providers.

<table>
<tr><td colspan="4">External Medial Reviews
% Compliance</td></tr>
<tr><td></td><td>Date of Review</td><td>Essential</td><td>Non-Essential</td></tr>
<tr><td>Round 4</td><td>November 2011</td><td>82</td><td>83</td></tr>
<tr><td>Round 5</td><td>March 2012</td><td>94</td><td>94</td></tr>
</table>

The data provided represented improvement in those areas assessed by the audits. Round 5 showed slightly less than 80% compliance with documentation of allergies and ADRs, approximately 50% compliance with documentation of explanations for failure to provide preventive services and approximately 65% compliance with responding to QDRRs within 15 working days.

In addition to the audits for overall care, the Round 5 audits included an assessment of the provision of care related to diabetes mellitus, pneumonia, and osteoporosis. The audit tools included 12 pneumonia items, six diabetes items, and seven osteoporosis items. Each of the audit items pertained to an action taken by the provider. There was no assessment of clinical outcomes. The findings of the audit are summarized in the table below.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Disease Management % Compliance			
	Diabetes Mellitus	Osteoporosis	Pneumonia
Internal Reviews	81	63	50
External Reviews	100	80	71

As noted in previous reports, the QA department generated corrective action plans following each review. The department also conducted follow-up of those action plans. The plans addressed each individual provider and that was appropriate for most situations. Very low compliance rates suggested the existence of a systems issue. The facility must be cautious about implementing corrective actions that do not address the underlying problems. This is where the appropriate use of performance improvement methodology and root cause analysis demonstrates its greatest value. The facility must ensure that corrective actions have adequately addressed the issues/root causes that resulted in compliance low compliance scores.

Mortality Management at MSSLC

There were six deaths in 2011. There was one death in 2012 at the time of the onsite review. The mortality documents for the four individuals who died since the last onsite review were requested including all clinical and administrative death reviews. All corrective action plans related to mortality reviews and the status on previous recommendations were also requested. While mortality documents were provided, the log of corrective actions was reported as not available. Information for the four deaths is summarized below:

- The average age of death was 80
- The causes of death were: acute myocardial infraction, pneumonia and myelodysplastic syndrome, pneumonia and failure to thrive, and pneumonia with septic shock
- No autopsies were completed

Thirty clinical recommendations related to various educational, training, and systems issues were generated as a result of the four mortality reviews. The administrative reviews resulted in four recommendations including:

- Development of a plan to discuss autopsies for imminent deaths
- Revision of the procedure Death of a Client
- Review of a PNMT policy for timelines
- Amendment of an ISPA summary

The monitoring team met with the medical director, chief nurse executive, and the two QA nurses to discuss mortality management at MSSLC. While the monitoring team understands that the Administrative Death Review Committee may decline the

#	Provision	Assessment of Status	Compliance
		recommendations of the Clinical Death Review Committee, the facility must address valid recommendations that are made by the members selected and appointed to the Clinical Death Review Committee. Both QA nurses expressed concern that the mortality process was not adequately addressing findings of the clinical death reviews. Specifically, it was reported that there was a failure on the part of the nursing department to implement corrective actions that adequately addressed the areas of concern. External mortality reviews were completed by the Quantros organization. The monitoring team was not granted access to that information. The medical director was asked how the facility used the information. She informed the monitoring team that she reviewed the information and filed it. She did not discuss it with the facility director or the Clinical Death Review Committee members because she believed it was "secret." It appeared that this service provided little value to the facility since the members of the Clinical Death Review Committee received no information and no discussions occurred with the facility director. The CNE and two QA nurses indicated that they were unaware that any feedback on the external mortality reviews was received. This served as further evidence that the facility's mortality review system was simply not functioning properly. Finally, it was abundantly clear that mortality management at MSSLC was in need of substantial review and reorganization. For the four deaths that occurred since the last review, the facility could not demonstrate what, if any, actions occurred in response to the various reviews that were completed. Review of mortality documents and records indicated that follow-up and corrective actions were warranted. The monitoring team would also like to make clear that records should not be amended following the death of an individual as recommended in one administrative death review.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility had not developed a structured medical quality program. A comprehensive set of measures had not been identified. The medical director focused on the internal and external audits as the quality program. Thus, the monitoring team engaged in a lengthy discussion with the medical director and the medical compliance nurse on the audit process and the development of a medical quality program. The disease management audits were conducted in March 2012 and assessed the quality of care provided for individuals with diabetes mellitus, osteoporosis, and aspiration pneumonia. State office had issued guidelines for the management of the three conditions, but the guidelines for diabetes and osteoporosis were not reviewed with the medical staff until the week of the onsite review. The medical director was not certain when the guidelines were issued by state office, but reported that they were retrieved from the shared drive. The documents provided were not dated.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The diabetes audit consisted of six questions, which related to the actions of the provider, such as listing diagnosis on the APL, ordering consults if warranted, and ordering labs. All items pertained to processes. Clinical outcomes were not assessed. Many other processes could have, and should have been assessed, such as those included in the state issued clinical guidelines, so this would be relatively easy to do. Achieving a good mix of indicators is important. For example, audit question #2 assessed the clinician's ordering of labs such as HbA1c. This was valuable information to have in assessing the quality of medical care provided, but it was not sufficient. The facility needed data on what percentage of individuals met the therapeutic target or had a good clinical outcome. This principle should be applied to all of the disease management quality audits keeping in mind that every item will not require or have both components. The target HbA1c is a critical monitor in diabetes management. A number of databases were developed to collect data on several aspects of medical care, such as the provision of some preventive services, constipation, and seizure management. These data, if accurate, could have been used to help assess quality of care. Unfortunately, the development of databases in the medical department appeared to be limited to those that would provide information for the document requests submitted by the monitoring team. It was also clear that the facility staff needed guidance and training on appropriate selection of meaningful data as well as how to use that data. The self-assessment indicated that .3% of individuals who required colonoscopies had not completed the procedure and had not been scheduled for the procedure. The monitoring team determined from the same data that 17% of individuals had pending referrals and overall 41% of individuals had no documentation of colonoscopy. Those were two very different results with two very different implications. The facility must understand that inaccurate data and incorrect use of data will not identify problems and will make meaningful use of the data impossible. Data should drive the decisions. In summary, the medical department relied on the internal and external audits to assess the quality of medical care. There was no evidence that the data collected (e.g., seizure, osteoporosis, bowel, hospital) were used for assessing the quality of care. There were no other quality initiatives in the department to assess the quality of care provided. The department did not monitor every individual with diabetes. In moving forward with this provision, the medical director should review Provision L1. The content of provision L1 demonstrated that the monitoring team assessed structural (staffing and services available), process (documentation and provision of services), and clinical outcomes (aspiration rates, bowel obstructions, diabetes targets) to assess the quality of medical care. The facility will need to develop a comprehensive set of indicators that includes, at a minimum, a mix of process and outcome indicators in order	

#	Provision	Assessment of Status	Compliance
		to move towards substantial compliance with this provision item. Moreover, the facility will need to demonstrate that indicator data are collected, analyzed, and trended. When trends are not favorable, an appropriate performance improvement methodology should be utilized to ensure remediation is achieved. The development of such a program was discussed in detail with the medical director and medical compliance nurse during the onsite review.	
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 facility implemented the state issued clinical guidelines on enteral feeding, aspiration risk reduction, constipation/bowel management, seizure management, and urinary tract infections. The state issued preventive care guidelines were also implemented. The most recent issued guidelines were for osteoporosis and diabetes mellitus. Flowcharts as well as detailed guidelines were provided. Both were well done and consistent with the current literature. The guidelines were evolving nicely. Each guideline that was issued from state office provided more information to the medical staff on management of medical conditions. The osteoporosis guidelines served as a "mini-text" that the medical provider could refer to when necessary. It provided a great reference on risk assessment, diagnostics and medical management of osteoporosis. The medical staff should utilize this and the diabetes guidelines as resources. The facility had not done any additional work in this area. In other words, the facility discussed and implemented state guidelines but no local polices based on these guidelines were developed and this was needed. The facility needed to localize the preventive care policy. Meeting minutes documented discussions of the need to do additional work in the area of aspiration management but no additional protocols were developed. It also appeared that there was some delay in the implementation at the facility level of clinical guidelines. Protocols that were issued in February 2012 were not implemented until the week of this onsite review. The facility needed a process for development of guidelines and protocols to ensure that they were appropriately implemented, assessed for effectiveness, and were regularly reviewed and revised.	Noncompliance

Recommendations:

1. The medical director should track physician attendance at ISPs, possibly using data that are already collected (L1).

2. The medial director should work with the PCPs in order to improve the quality and accuracy of required documents, such as the Annual Medical Summaries, Quarterly Medical Summaries, and Active Problem Lists as discussed in the body of the report (L1).

3. If not already done, the medical director should proceed with implementing the state issued QMS template (L1).

4. The medical director should determine why consultants are not receiving all required information such as seizure logs and laboratory data to complete consultations (L1).

5. The medical director should ensure the all individuals' Hepatitis B immune status is clearly documented. There should also be a protocol to ensure that individuals are assessed for the need to receive the booster vaccination (L1).

6. The medial director should proceed with implementing the revised Preventive Care Flow Sheet (L1).

7. The medical director should ensure that a though risk benefit analysis is completed when determining the appropriateness of preventive screenings. Input should be solicited from the entire team including the individual/legally authorized representative when appropriate (L1).

8. In order to improve the quality of the documentation of neurology care, and ensure that individuals are receiving appropriate and timely care, the medical director should consider the use of a template that includes the key information that is needed in providing care to those with seizure disorders (L1).

9. The facility should build on he current work being done with the pneumonia reviews. Please refer to discussion in body of report (L1).

10. The facility must ensure that the data it is collecting and using to make decision regarding care is accurate and reliable (L1).

11. The facility must ensure that appropriate corrective actions are implemented for deficiencies identified during the quality audits. Very low compliance scores should trigger a search for process and systems problems (L2).

12. The disease management component of the quality audits need to be expanded to capture clinical outcomes in addition to processes (L2).

13. Mortality management at MSSLC must be reviewed and restructured to ensure that there is accountability for the actions occurring at the facility (L2).

14. The facility should review its mortality management and ensure that appropriate corrective actions have occurred particularly when reviews present recurrent issues related to the provision of care. The nursing department should track all corrective actions recommended and implemented (L2).

15. The facility must develop a quality program based on a comprehensive set of process and outcome indicators in addition to the quality audits that are occurring (L3).

16. The facility must demonstrate that indicator data is collected, analyzed, and trended. When trends are not favorable, an appropriate performance improvement methodology must be utilized to ensure remediation is achieved (L3).

17. The medical director must ensure that state-issued clinical guidelines are implemented in a timely manner. Protocols should be developed when data indicate it is warranted (L4).

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 Self-Assessment o Seizure management policy and form (new) o Alphabetical list of individuals with current ISP, 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 Medical Emergency Response Committee Meeting Minutes – 9/1/11-2/12 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 3/1/12 MERC meeting minutes o CNE investigation of 11/17/11 DFPS referral

	o All nursing policies, procedures, and guidelines developed during 9/1/11 – 3/26/12 o All policies and procedures re: Employees Minor Care Clinic o Job description for Program Compliance Nurse and Skin Integrity/At-Risk Nurse o All policies and procedures re: SANE o All policies/process that address minimum staff levels for Nursing Department o List of nurses delinquent in iLearn o State Office guidelines for pre-services training requirements in infection control o Nursing Services Policy N.S.3, N.S.6 o Nursing Department's response to the QI Death Reviews of Individual #542, Individual #515, Individual #322, and Individual #229 o Infection Control Prevention Tools completed during 1/1-3/27/12 o Infection Control Tracking/Trending data sorted by individual for the period 10/1/11-3/27/12 o Number of employees delinquent with TB testing as of 3/27/12 o Employee Injury Treatment Report o Number of employees treated at Minor Care Clinic by month since its inception o Employee Injury Clinic Quick Reference Protocol o PETII Meeting Minutes (past six months) o Records of: • Individual #227, Individual #386, Individual #341, Individual #17, Individual #32, Individual #124, Individual #178, Individual #237, Individual #391, Individual #96, Individual #562, Individual #405, Individual #135, Individual #353, Individual #556, Individual #204, Individual #160, Individual #203, Individual #435, Individual #369, Individual #272, Individual #424, Individual #508, Individual #448, Individual #248 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Norris Buchmeyer, RN o Nursing Operations Officer, Mary Jane Cotton, RN o Quality Assurance Nurses, Karen Wilson, RN, Dawn Price, RN o Hospital Liaisons, Rosemary Roberts, RN, Laura Taylor, RN o Nurse Educator, Paulette Caldwell, RN o Assistant Nurse Educator, Genia Duke, RN o Nurse Compliance Monitor, Gabby Brewer, RN o Skin Integrity/At-Risk Nurse, Cheryl Trantham o SAM/HIP Nurse, Amber Wright, RN o Shamrock Nurse Manager, Amy Isabell, RN o Barnett Nurse Manager, Lisa Brown, RN o PNMT RN, Loretta Gallegos, RN o Director of Habilitation Therapy, Brandie Howell <u>Observations Conducted</u>: o Medication Administration (Martin 3, Martin 5, Barnett 7, Barnett 8, Central 7, Longhorn 6) o Enteral Feeding (Martin 5)

	o Enteral Administration of Medications (Martin 5) o Validation Exercise (Barnett, Martin, Shamrock, Longhorn, Whiterock) o Infection Control Committee Meeting – 3/26/12 o Skin Integrity Committee Meeting – 3/26/12 o Clinical Services Meeting – 3/29/12 o Nurse Manager Meeting – 3/27/12 o Medication Error Committee Meeting – 3/29/12 o Shamrock Focus Meeting – 3/29/12 o Martin ISP Meeting – 3/29/12 o Self-Assessment Monitoring Meeting – 3/28/12
	Facility Self-Assessment: MSSLC submitted its self-assessment, which was updated on 2/21/12. Since the prior review, MSSLC made a number of revisions to its self-assessment process and separated the report into three separate sections. The self-assessment now stood alone as its own document and described, for each provision item, the activities the facility engaged in, the results, and the rating associated with its self-assessment. This was a marked improvement in the facility's self-assessment process. During the conduct of the onsite review, the monitoring team reviewed the self-assessment with facility staff members and provided feedback on ways in which the process could be further improved. For example, there were recommendations made to help clarify the somewhat subtle difference between assessing whether substantial compliance was achieved versus engaging in activities to meet substantial compliance. Other food for thought included the following: • Do not rely solely on the results of the statewide self-monitoring tools as the measure of compliance. The tools may be one of several activities used to self-assess, but will not likely be sufficient to gauge substantial compliance. • Consider what the monitoring team evaluates and the activities they engage in to evaluate compliance. Their activities extend beyond completion of monitoring tools and almost always involve direct observations and assessment of outcomes for individuals served by the facility. • When percentages, also known as "scores," are added together and divided by a total number of averaged percentages/scores, they become watered down and less reflective of reality. • Reliability does not mean validity. These two distinct concepts are both important to measure and incorporate into evaluation and self-assessment activities. According to the Chief Nurse Executive and Center Lead for section M, at the time of the updated self-assessment, the facility's self-ratings indicated that it was in compliance with two of the six provisions of section M. On the basis of all monitoring activities undertaken by the monitoring team, the monitoring team was not in agreement with the facility's self-ratings. That being said, the current review continued to reveal evidence of substantial compliance in a number of the actions steps related to several of the components of assessment and reporting protocols, integration of

	clinical services, and medication administration.
	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. The CNE reported that since the prior monitoring review, the Nursing Department had many accomplishments and improvements in all areas. He was correct. 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, many documents were reviewed, a number of residential areas were visited, daily observations of nursing care were made, 30 nurses were interviewed, and 25 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 many of the system improvements and processes were initiated and developed at the top of the Nursing Department's organizational chart. During the review of individual's records, it became clear to the monitoring team that in order for MSSLC to achieve substantial compliance with the provisions of section M, all nurses, from LVN to CNE, must be present, available, and competent to do their job and implement the systems developed to help them succeed. For example, the review continued to find problems with nurses who failed to respond appropriately to ensure adequate follow-up for individuals who had suffered acute illnesses and injuries. In addition, there were nurses who failed to implement many of the assessment and reporting protocols for the majority of the individuals reviewed. These failures jeopardized the individuals' health and safety and placed them at risk of harm. These examples, and others described throughout the report, were indicative of the challenges that lie ahead. Notwithstanding these problems and challenges, there were many good changes and tremendous potential for further accomplishments.

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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.	Since the prior monitoring review, the Nursing Department showed positive changes that were demonstrative of six months of work towards substantial compliance with the provisions of section M. The nurses who occupied positions of leadership within the department continued to demonstrate, by all observations, that they were a strong and capable team of nurses who were helping the facility achieve substantial 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. According to the facility's self-assessment, since the prior monitoring review, although the Nursing Department had concluded that they made great improvements in many areas, the results of their self-monitoring of "pain and skin integrity were bringing down [their] total composite score." Thus, as of the review, they reported that they were not in substantial compliance, "...as there just had not been enough months of sustained composite score above 70% in all of the six areas we are monitoring." The monitoring team agreed with the facility's finding of noncompliance, but based its rating on evidence of the presence and adequacy of assessment, reporting, documenting, planning, communicating, monitoring, and evaluating significant changes in individuals health status sufficient to help ensure that the changes were readily identified and addressed. During the conduct of the monitoring review, all presentation books and all documents submitted by the facility were closely examined, many residential areas were visited, daily observations of nursing care were made, 30 nurses were interviewed, and 25 individuals' records were reviewed. All told, and consistent with the CNE's findings, it was clear that there were improvements in all areas and many accomplishments were made by the Nursing Department. However, also consistent with the findings and conclusions in the facility's self-assessment, the monitoring review revealed that there continued to be problems ensuring that nurses' adequately identified of health care problems, performed complete assessments, implemented planned interventions, conducted appropriate follow-up, and kept appropriate records to sufficiently and readily identify and address the significant changes in individuals' health status and needs. Thus, a rating of noncompliance was made in this area. <u>Recordkeeping and Documentation</u> As noted in the prior review, all individuals' records were organized in a unified form/format. Individuals' notebooks were present on their homes and available to direct caregivers. Notwithstanding these positive findings, there were a number of recordkeeping and documentation problems found in the 25 records selected and submitted by the facility for review. For example:	Noncompliance

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		• Strikingly, despite the presence of multiple pressing health needs across all of the sample individuals selected for review, almost half (12) of the 25 individuals' records failed to have either a health management plan (7) filed in their record, or they had many pages of their existing HMPs missing from their records (5). This was an especially significant negative finding that impacted upon the findings, and noted in detail, in other provision items, including M3, M4, and M5. • Also of notable significance, over one-third (9) of the 25 individuals' records failed to have a current quarterly nursing assessment filed in their records. That is, nine individuals' most current quarterly nursing assessments were completed either on or before 12/15/11 and were two weeks or more past due. • In addition, two of the 25 individuals' records were missing quarterly nursing assessments for the period of 5/11-8/11 and 6/11-9/11. • One of the two sample individuals recently admitted to MSSLC had an admission assessment that was not completed until over 30 days after the individual's admission to the facility. • Two of the 25 individuals failed to have current, annual ISPs filed in their records. • A significant number of nurses' notes were out of date/time sequence on the same page and/or across several pages of the IPNs. • Occasionally, entries were documented on the margins of the IPNs versus starting a new page. • Errors in entries were not consistently and properly identified as such. There continued to be obliterated and partially obliterated entries usually due to nurses' who attempted to write over incorrect entries of dates, times, and findings with corrected/revised information. • Slang, such as the word, "dungeon" to indicate a location at the facility, and cryptic phrases, such as, "Neuros intact for him," was found in nurses' notes. • As noted in prior reviews, a number of nurses' names and credentials continued to be illegible. <u>Hospitalization and Hospital Liaison Activities</u> According to the state's 5/11/11 Nursing Services Policy, "The State Center Nursing Department will ensure continuity of the planning, development, coordination, and evaluation of nursing/medical needs for all individuals admitted to or discharged from the hospital to the infirmary or moving between facilities. The hospital liaison will make periodic visits to a hospitalized individual to obtain as much up- to-date information as possible from the hospital nurse responsible for care of the individual. Information gained will include, but not be limited to diagnosis, symptoms, medications being given, lab work, radiological studies, procedures done or scheduled with outcomes, and plans for discharge back to the State Center."	

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		Four of the 25 individuals selected for in-depth review were hospitalized one or more times during the period of 9/30/11 – 3/30/12 for treatment of significant changes in their health. In accordance with the state's clear policy directives and the provisions of the Settlement Agreement, all of the individuals who were hospitalized had daily Hospital Liaison Reports filed in their records. These reports revealed evidence that the individual was visited and/or his/her tertiary care providers were contacted by either the nurse Hospital Liaison or Assistant Hospital Liaison throughout the hospitalization. • For example, a review of Individual #341's record revealed that she was hospitalized for treatment of aspiration pneumonia and respiratory failure. At least daily, contacts were made with her tertiary care providers for status updates and coordination of care between the hospital and MSSLC. Prior to Individual #341's return to the facility, a post-hospitalization nursing assessment was conducted, and a meeting was held with her IDT. The nature and timeliness of the Hospital Liaison's communication and collaboration with Individual #341's tertiary care providers and her IST members played a vitally important role in helping to ensure that Individual #341's health and safety needs were identified and addressed upon discharge from hospital. This was especially significant for Individual #341, who was also recovering from a gastrostomy and adjusting to a newly acquired enteral feeding tube. Also since the prior review, on or about 11/4/11, the Hospital Liaisons began meeting with all hospitalized individuals' IDTs prior to their discharge to help teams learn about the individuals' new health risks, reconsider their prior levels of health risk, and help plan for their smooth transition from the hospital setting to their home unit. Their contributions to the ISP/ISPA processes were well done, well received, and in accordance with the facility's 1/12/12 nursing protocol regarding hospitalizations, transfers, and discharges. The Hospital Liaisons also continued to regularly attend and participate in various committee meetings, such as Skin Integrity, Medication Error Reduction, Nurse Specialty, and Ethics/Hospice Committee; where they communicated and collaborated with other team members to promote continuity of care and, in their words, develop "rapport with everyone." <u>Wound/Skin Integrity</u> According to the state's 5/11/11 Nursing Services Policy, "Individuals will be provided with nursing services in accordance with their identified needs...[and] nursing services includes participation in a Skin Integrity Committee that includes medical, dietary, nursing, specialized therapy, pharmacy, quality assurance, and residential services staff. The committee reviews data related to skin integrity issues, analyzes data for patterns and formulates recommendations for preventative measures and management."	

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		During the prior review, the Skin Integrity Nurse was working very closely with the Habilitation/Therapy Department, and especially with the physical therapist that was certified in wound care, conducting skin integrity meetings twice a month, and attending unit-based Weekly Focus Meetings where she shared wound care tracking/trending data and informed direct care staff members, nurses, and other clinical professionals about the skin care needs of the individuals who resided on the units. However, since the prior review, the Skin Integrity Nurse had transferred to the Quality Management department, and, as of the week prior to the monitoring review, an RN from the Martin unit had assumed the newly created position of Skin Integrity/At-Risk Nurse. The new Skin Integrity/At-Risk Nurse, who was not new to MSSLC, brought to the position a working knowledge of many of the individuals who suffered risks of alteration in skin integrity. Nonetheless, during the monitoring team's interview, it was clear that the Skin Integrity/At-Risk Nurse had not been adequately apprised of the expectations of her position or her job duties prior to assuming the position. For example, during the interview, the Skin Integrity/At-Risk Nurse was unable to explain how she planned to (1) identify and/or receive timely notification and timely intervene on behalf of individuals with alteration in skin integrity, (2) adequately prepare prior to attending ISPs/ISPAs where she was supposed to give advice and guidance to RN case managers and other team members regarding the assignment of levels of individuals' health risks, and (3) schedule her days to accommodate the competing demands of her job beyond her simple desire to "go to as many [meetings] as I can." The Skin Integrity/At-Risk Nurse candidly reported that she had "no overlap" with the former wound/skin care nurse and received no guidance or direction on how to proceed with carrying out her new job. In addition, she had not been afforded assistance with establishing communication, coordination, and collaboration with key clinical professionals, such as members of the PNMT. Thus, it was strongly advised by the monitoring team that the new Skin Integrity/At-Risk Nurse actively seek out and receive adequate support, guidance, and direction on how to implement the expectations and duties of her job as a member of the nursing administration team . <u>Infection Control</u> During the prior review, the NOO was also carrying out the responsibilities and duties of Infection Control Nurse. Wherever and whenever a need for infection control training, education, and/or monitoring was identified, the NOO/Infection Control Nurse was present, able, and willing to provide advice, training, and onsite mentoring for all employees and individuals. On or about 1/1/12, a new Infection Control Nurse was appointed to the position, but no ground was lost before, during, or after the transition period. This positive finding was in part due to the NOO's continued involvement and	

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		support of the facility's infection prevention and management program. For example, the review of sample individuals' records revealed that several individuals with infectious diseases were promptly identified, treated, and followed by clinical professionals until their conditions were resolved. Approximately one month after Individual #204's admission, he was diagnosed with hookworms. Individual #204's record revealed that the Infection Control Nurse was appropriately notified of his diagnosis, and she provided assistance to his case manager with developing a health management plan and instructions for the direct care staff members regarding "good hand hygiene and ways to prevent transmission of the infection." There was also evidence that the Infection Control Nurse notified other relevant facility department directors, the State Health Department, and the CDC to ensure that all infection prevention protocols and precautions were implemented in a timely manner. Of note, Individual #204's infection was effectively treated and contained. There were other individuals, however, whose records revealed that, although they presented challenges to the standard infection control and prevention interventions and plans, they had not been referred to the Infection Control Nurse. For example, Individual #448 was a 64-year-old man who notoriously "refused many health services" and was noncompliant with medical professionals recommendations for most of his vaccinations/immunizations. In addition, according to Individual #448's 2/10/12 nursing assessment, he "keeps his own food in a locked, personal refrigerator and will not let anyone look and see what is in it." Despite Individual #448's risk of infectious diseases, food-born illnesses, and infections, etc. there was no evidence that the Infection Control Nurse was notified of this situation or that her expertise was brought to bear to help this IDT develop strategies vis a vis risk action plan and reduce his risk of infection. During the review, the monitoring team attended the Infection Control Committee meeting. The meeting, which was led by the 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 new strategies to improve tracking, follow-up, and prevention of urinary tract infections, employee adherence to TB testing, unit-specific teaching regarding MRSA, VRE, and c.difficile infections and precautions, and a review of infection tracking and trending data, etc. As noted in the prior report, it was apparent that the Infection Control Nurse had continued the former Infection Control Nurse's involvement in most aspects of nursing assessment and reporting. During the monitoring team's interview with the Infection Control Nurse, she gave several examples of ways in which MSSLC had continued to progress toward their goal of "preventing infectious processes and providing teaching to employees and individuals."	

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		One such example was that the Infection Control Nurse was in the process of investigating individuals diagnosed with a confirmed pneumonia for evidence that they received modified barium swallow studies in their recent/remote histories. She was also working with the facility's Competency Training & Development department on the production of an instructional video for employees and individuals, where appropriate, on proper, hygienic showering/bathing procedures. The Infection Control Nurse continued to review sick call sheets/logs, read 24-hour reports, and 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 Infection Control Nurse continued the practice of bringing new and relevant information, including journal and newspaper articles, to the facility's Infection Control Committee to help keep the members informed about the latest developments in the arena of infection control and prevention. <u>Emergency Response</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 Emergency Drill Checklists for November 2011 through February 2012 revealed that many fewer drill checklists (n=180) were submitted for review than were submitted during the prior review's evaluation of these data, which were submitted as evidence of medical emergency drills conducted during April 2011 through July 2011 (n=392). Since there were no changes in the state's Emergency Response policy or the facility policies/procedures addressing medical emergency drills, it was unclear why 54% fewer drills were conducted. There were no references to a discussion or explanation of this matter in the minutes recorded from the "Medical ER Response Meetings" that were held over the past six months. As noted during all prior reviews, there continued to be many drills conducted, but not attended and/or participated in by nurses and/or other clinical professionals who were providing direct services to the individuals. For example, during January 2012 to February 2012, nurses responded to only approximately one-half of the drills conducted. Thus, the assessment of the response of the "first nurse on the scene," was almost always	

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		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." Other clinical professionals, such as physical therapy assistant, rehabilitation technician, and psychiatry assistant, responded to less than 5% of the drills conducted during the two-month period. No other clinical professionals, such as therapists, psychologists, psychiatrists, physicians, etc., participated in the medical emergency drills. Although this problem was cursorily referenced during the 12/15/11 "Emergency Medical Drill Committee Meeting Summary," there was no follow-up to ensure an adequate and appropriate resolution. Another problem identified during the monitoring team's review of the Emergency Drill Checklists and the Emergency Medical Drill database was that, although the database indicated that certain drills were "passed," the Emergency Drill Checklists clearly indicated that serious problems were identified during the conduct of the drill and these problems were not completely addressed and/or rectified with on-the-spot correction and/or training by the Drill Instructor at the time of the drill. The following examples were illustrative of this problem: • On 2/29/12, the Emergency Drill Checklist indicated that no equipment was brought to the scene, the nurse "told staff <u>not</u> to get the AED cart," and "nursing failed per [MSSLC employee]." Despite these serious problems, the February 2012 Emergency Medical Drill database indicated that this drill was "passed." • On 2/21/12, the Emergency Drill Checklist indicated that no equipment was brought to the scene, the "ramp [was] blocked by furniture," "staff stated they have not been inserviced on medical emergency cart," "it took 20 minutes to get the medical cart," and that there were "<u>Not enough staff</u>." Notwithstanding these significant problems, and, apparently, as a result of the Drill Instructor's note that he/she, "Inserviced staff about obtaining medical cart [and] competency demonstrated," this too was a "passed" drill. • On 2/17/12 an almost entirely blank Emergency Drill Checklist was scored as a "passed" drill. The above-referenced problems were only few of the many problems noted during the monitoring team's review of the integrity of the medical emergency drill data. It was strongly recommended that the oversight of these data and their associated health and safety activities be taken as seriously as the life and death matters they represent. <u>Other Significant Changes in Individuals' Health Status</u> According to the Health Care Guidelines, all health care issues must be identified and followed to resolution. In addition, documentation of the Integrated Progress Notes (IPNs) must include all information regarding the status of the problem, actions taken, and response(s) to treatment at least every day to ensure that treatment is appropriate	

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		and recovery underway until such time as the problem is resolved. In addition, the state's Nursing Services Policy stipulated that nursing staff members must document all health care issues and must have follow-up documentation reflecting status of the problem, actions taken, and the response to treatment at least once per day until the problem has resolved. Across the 25 individuals reviewed, there was evidence that their physicians responded to nurses' notifications of significant changes in their health status and needs and/or when the individuals needed to be seen, usually within less than 24 hours. However, there were many examples of occasions when nurses failed to notify individuals' physicians of changes in the individuals' health status and needs in a timely manner. Thus, there were delays in the assessment, treatment, and follow-up of individuals' health needs and risks. There were also many examples of occasions when nurses failed to conduct at least daily follow-up until resolution of the significant changes in individuals' health status occurred. The following examples represented the seriousness of this problem at MSSLC. There was one or more of these types of occurrences found in 22 of the 25 records reviewed. • On 10/28/11, at 3:30 pm, Individual #435's nurse noted that he had a small amount of bleeding at his gastrostomy tube site. Individual #435's nurse applied sliver nitrate stick to cauterize the bleeding, and recommended, "Monitoring for ↑ bleeding." Over the next several days, no follow-up occurred, and it was not until 11/1/11 at 4:30pm that Individual #435's physician noted, "Black discharge from around Individual #435's gastrostomy site. It is guaiac positive. Upper GI bleed recently." At this time Individual #435's physician planned to "Continue [medications], check complete blood count, and get GI consult," and concluded that, "Individual #435 does not appear to be bleeding heavily at the moment (sic)." Notwithstanding the significant change in Individual #435's health status and risk of complications related to possible gastrointestinal bleeding, there was no follow-up by his nurses until the next day when additional bleeding was again found. Of note, there was also no evidence of follow-up to Individual #435's physician's order for a GI consult. Thus, it was not until over four months later, on 3/14/12, that a gastroenterologist evaluated Individual #435. • Over the past several months, Individual #248, who had poor circulation to her feet and was at high risk of alteration in skin integrity and risk of falls and injuries, including fractures, frequently reported to her nurses, "My feet hurt." At the time of Individual #248's complaints of pain, her nurses usually conducted a limited assessment of her feet, administered pain medication, and sometimes they conducted a follow-up monitoring of the effectiveness of the medications,	

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		and sometimes they did not. In addition, although one of Individual #248's nurses identified that her frequent complaints of foot pain were most likely associated with new orthopedic shoes that were too tight and he/she planned to "inform the morning nurse that individual's shoes may be too small" and "follow-up initiated – will monitor for any changes," there was no evidence that follow-up occurred. Left unaddressed, it was not surprising that during this same time period the Skin Integrity Committee had identified a pattern of problems with individuals refusing to wear their special shoes/insoles because their feet hurt. • Individual #124 was a 23-year-old man diagnosed with diabetes and hypertension and at risk of the complications of these diseases, such as vision impairment related to neuropathies. Upon admission, Individual #124's 2/14/12 initial visual screening examination at the MSSLC Eye Clinic concluded that he was unable to read the letters or numbers and, "Patient appears to be visually impaired on this date." The examiner recommended that Individual #124 receive further evaluation and refraction. Although Individual #124's nurse noted the results of this examination, there was no evidence of follow-up to this significant finding.	
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.	In accordance with the provisions of the Settlement Agreement, 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. In addition, a review of the state's guidelines for completing the comprehensive nursing assessments revealed that they clearly required the comprehensive nursing assessments to be completed prior to and in anticipation of the individuals' annual and quarterly ISP meetings. Thus making it imperative that the Nursing and QDDPs/ISP Coordination Departments closely coordinate, communicate, and collaborate with each other. According to the facility's self-assessment, they were in substantial compliance with this provision item because they identified "great improvement not only with monitoring scores, but with follow-up actions in identifying problems with assessments and presenting them to the individual nurse to improve their assessments." In addition, the facility reported that they demonstrated "a capacity to self-correct [vis a vis] continuous process dedicated to improvement with our current systems of orientation, training, monitoring, corrective actions, and disciplinary actions."	Noncompliance

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		Without a doubt, the monitoring review revealed improvements in the nursing assessments of the nursing care needs of individuals served by the facility. It was also duly noted that MSSLC had indeed developed systems to identify problems and take corrective actions. However, the monitoring review of the 25 sample individuals' records revealed overwhelming evidence that despite the facility's improvements in monitoring, identifying, and responding to problems, the majority of the individuals' quarterly, annual, and as-needed nursing assessments failed to meet the standards set forth by the state's policies, protocols, and guidelines and the provisions of the Settlement Agreement. As a result, a rating of noncompliance was given to this provision item. Over one-third (9) of the 25 individuals' records failed to have a current quarterly nursing assessment filed in their records. That is, as of 3/30/12, nine individuals' most current quarterly nursing assessments were completed either on or before 12/15/11 and were two weeks or more past due. In addition, two of the 25 individuals' records were missing quarterly nursing assessments for the period of 5/11-8/11 and 6/11-9/11. And, one of the two sample individuals recently admitted to MSSLC had an admission assessment that was not completed until over 30 days after the individual was admitted to the facility. The review of the remaining 13 individuals with currently dated nursing assessments revealed that eight of the 13 individuals' assessments (62%) 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. The remaining five individuals' assessments were indeed comprehensive reviews of the individuals' medical and health status information, but, like the rest of the sample individuals' nursing assessments, their assessments failed to result in a complete, accurate list of the nursing needs of the individuals, such that the individuals would receive proper care and achieve and maintain their desired levels of health based upon adequate interventions articulated in comprehensive nursing care plans. Thus, as noted in all prior reviews, the conclusions (i.e., nursing diagnoses) drawn from the assessments failed to consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This continued to be a serious problem because the HMPs, and the selection of interventions to achieve outcomes, were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments.	

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		Across the 13 sample individuals' assessments reviewed, over half of their comprehensive nursing assessments had most of the deficiencies described below: • Lists of current active medical diagnoses were incomplete and not up-to-date, • Most failed to reference meaningful reviews of individuals' response to and effectiveness of all of their medications and treatments, • When significant weight changes were documented, there were no evaluations of the nature and impact of the changes on the individuals' health status, • Tertiary care reviews were incomplete and often missing important information that would clarify why the individuals were hospitalized or otherwise treated by tertiary care professionals, • Individuals' significant histories of chronic and acute conditions, including, but not limited to, genetic syndromes, metabolic disorders/syndromes, aspiration pneumonias, chronic diseases, contagious diseases, sensory impairments, etc., were not completely identified and evaluated, • Nursing assessments frequently failed to reference an assessment of individuals' pain. On occasion, although the PAINAD was referenced as a tool that was used to evaluate pain, there was no further information provided in the nurses' assessment about the individuals' pain. • Individuals' persistent, recurring problems (e.g., alteration in skin integrity, infection, diarrhea, constipation, insomnia, etc., were sometimes noted by their nurses in the nursing assessments, but frequently they were not. Thus, they were not adequately evaluated, diagnosed, or addressed vis a vis care plans. • Frequently, the conditions of individuals with severe contractures, spasticity, scoliosis, and other deformities were not accurately portrayed. Rather, the "musculoskeletal" sections of the nursing assessments were either missing information, blank, or indicated that there were "no abnormal findings." • Lists of nursing problems/diagnoses were incomplete, and • Nursing summaries, especially those that accompanied annual nursing assessments, were uninformative, confusing paragraphs of incomplete, run-on sentences, with cut/copied and pasted lists of discrete events, medication changes, appointments, lab test results, clinic visits, etc. Typographical errors were frequent and not corrected from one assessment to the next. Overall, the summaries failed to provide any measure of an organized, thoughtful, recapitulation of the individuals' health status over the 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.	

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		The following examples from the sample of 13 individuals with currently dated nursing assessments indicated the seriousness of this problem at MSSLC. • Individual #124 was a 23-year-old man diagnosed with diabetes, hypertension, hyperlipidemia, seizure disorder, and hypercalcemia. He was admitted to MSSLC from the county jail. According to his "Nursing Admission Summary," his pain was assessed using the FLACC scale, but no numeric score was recorded. The assessment noted that he had scars on various parts of his body, but the diagram for "Body Identification Marks" was blank. In addition, the "Head to Toe Assessment Checklist" failed to reference his diabetes (endocrine disorder) and his blood sugar range. Of note, the section of his admission summary, "NCP/MCP Initiated for the Following Problems," was completed with one word - "None." • Individual #178 was a 64-year-old man who was diagnosed with multiple chronic conditions. The gastrointestinal section of his nursing assessment failed to reference his positive h.pylori infection; the respiratory section of his nursing assessment failed to reference exacerbation of his COPD; the oral hygiene section of his nursing assessment erroneously noted that he was edentulous and failed to reference his periodontal disease and caries; and although he was seen multiple times in sick call for alteration in skin integrity of his scrotum and treatment of macerated scrotal skin and non-healing wounds, the pressure ulcers/wounds section of his nursing assessment indicated that he had "No" problems/abnormalities. • A 40-year-old man had diagnoses of dementia, insomnia, schizoaffective disorder, HIV+, hypothyroidism, constipation, acne, chronic anemia, and nicotine dependence. Despite the complexity of his health needs, risks, and potential for complications, his nursing assessment provided nothing more than two words – "good" and "effective" – to document his response to and effectiveness of his medication regimen. In addition, there was no reference to his dementia, oblique reference to the use of a motion sensor on his bed at night due to his "inappropriate sexual behavior."	
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	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 intervention implementation. In addition, the state's 12/30/11 guidelines for the routine responsibilities of the RN case managers reaffirmed that, with regard to planning, they must actively participate in	Noncompliance

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	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.	ISPA meetings and IDT meetings to discuss and formulate plans of care to address the health risks, as well as other chronic and acute health needs or issues as they arise, for the individuals' served by the facility. The guidelines also indicated that RN case mangers were not to provide RN coverage for the unit/campus on any shift, not to be scheduled to work or provide RN coverage for the unit/campus on weekends or holidays, not to work as a campus RN, RN supervisor or Office on Duty, and not to provide supervision to other nurses. Thus, while the guidelines confirmed expectations for RN case managers, they also sought to ensure that RN case managers would be afforded adequate time and attention to focus on their main task – the quality, clinically optimal, and cost-effective management of the health care status and health care needs of individuals on their assigned caseloads. According to the facility's action plan, since the prior review, seven action steps were completed in an effort to improve performance and achieve compliance with this provision item. For example, according to the action plan, all acute and chronic nursing care plans and revisions were reviewed during the individuals' quarterly ISP and ISPA meetings. In addition, a procedure for tracking and monitoring the development and implementation of acute nursing care plans was developed and implemented. During the monitoring team's onsite review, across units, individuals' acute care plans were observed filed in care plan and follow-up notebooks. And, in general, nurses who were on-duty were knowledgeable of the individuals who had acute care plans in place. This was an improvement from the findings of prior reviews. The facility's self-assessment indicated that the results of the monitoring of nursing care plans revealed scores that ranged from 88% to 97% compliance with the expectations of the provision. Notwithstanding the very high compliance scores, the facility's self-assessment concluded that the provision was "not in substantial compliance...because we neither are monitoring enough care plans to acquire a true picture of compliance not monitoring enough care plans to impact the quality of the high numbers of care plans that are generated every month." The monitoring team agreed that the facility was noncompliant with this provision item, and based this finding on evidence of the facility's failure to 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. For example, it was striking that despite the presence of multiple pressing health needs across all of the 25 sample individuals selected for review, almost half (12) of the 25 individuals' records failed to have either a health management plan (7) filed in their	

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		record, or they had many pages missing from their existing HMPs (5). This was an especially significant negative finding that impacted upon the findings, and noted in detail, in other provision items, including M1, M4, and M5. Of the remaining 13 individuals with health care plans filed in their records, not one had all of their necessary health management plans with nursing interventions that addressed all of their health care needs, including their needs associated with high-risk or at-risk conditions. As a result, a rating of noncompliance was given to this provision item. Even so, there were two positive findings that bear reporting. Of the 25 sample individuals reviewed, one individual had one "At Risk for Respiratory Complications/Aspiration" health management plan filed in her record that was appropriately individualized (Individual #391), and one individual had all generic stock plans representing all of her health care needs present in her record and available to be individualized (Individual #248). And, during this review, individuals with acute health care needs were much more likely to have ACPs that were reviewed/resolved filed in their records than during the prior review. Some general comments regarding the 13 sample individuals with at least one complete health care plan filed in their record are listed below. • Individuals' records often contained many fewer HMPs than what was needed by the individuals, according to the health information filed in their records. • There were significant discrepancies between the interventions referenced in the plans, which were expected to be implemented, versus the actual delivery of health services and supports to the individuals, as documented in the IPNs. • Plans continued to be generic, "stock" mini-plans, and many failed to provide individualized person-centered interventions as a foundation for the achievement of positive, desired health outcomes. • In addition, the interventions failed to reveal that they were developed using current, evidence-based practices in order to make the best clinical decisions and recommendations for interventions to enhance and improve outcomes. • Also, as noted in the prior reviews, a small number of individuals' records included HMPs entitled, "Effective Therapeutic Regimen." These were catchall plans that referenced a variety of health issues, situations, and possible complications suffered by the individuals, but only very generally. And they broadly referenced just a few interventions, which were usually limited to providing health education, rationales for treatment, information regarding side effects and precautions, etc. o For example, Individual #17 was a 20-year-old man with end stage	

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		renal disease who required dialysis three times a week. He had only one HMP – a "3/8/12 Therapeutic Regimen Management, Ineffective (sic)" – filed in his record. The goals of his HMP were that he would (1) experience no complications or adverse effects related to his hemodialysis treatment, (2) demonstrate improved compliance with his specialized renal diet and fluid restrictions, (3) regain and maintain positive self-esteem and control of his life, and (4) continue to be productive in society by 5/5/12. Not only was the time-frame achieve his goals exceedingly unrealistic, <u>the only nursing interventions referenced by the plan were action steps related to his arteriovenous fistula care</u>. Thus, his one and only HMP completely failed to address his life-altering health problems, needs, and risks. • Although direct care staff members were assigned the largest share of individuals' personal care, across a number of HMPs and ACPs, there were either no instructions for direct care staff or very limited instructions. • There were either no time-lines referenced in the plans or the generic phrase of "...over the next 12 months," upon which nurses could conduct adequate and appropriate criterion-based evaluations of outcomes. • Thus, it was not surprising that changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes did not often trigger or result in revisions to their HMPs and ACPs. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #424 was a 21-year-old man who weighed almost 400 pounds on admission. Over the past year, Individual #424 failed to lose weight and suffered various health complications related to his morbid obesity, such as abnormal blood-lipid levels, low back pain, uncontrolled blood pressure, polyuria, polydipsia, polyphagia, etc. As of this review, he failed to have a health management plan in place to address this problem. • Over the past 18 months, Individual #135 lost over 40 pounds and was currently below the lowest limit of his desired weight range, but his record failed to include a plan to address his undesired, unplanned weight loss. Over the past six months, he suffered several falls, some with serious injuries to his head and face. There was no evidence that his plan was reviewed or revised subsequent to his falls. Strikingly, during Individual #135's 2/23/12 ISPA, when his team discussed his risk for falls and heard tell of his falls with serious injuries suffered during the quarterly review period, the team "agreed to continue the medium risk for falls." Neither his HMP nor his Risk Action Plan referenced adequate interventions to address his health needs, effectively reduce his risk of falls, and help ensure his safety.	

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		• During Individual #341's most recent 3/4/12-3/26/12 hospitalization for treatment of aspiration pneumonia and hypoxia, she underwent a gastrostomy and placement of an enteral feeding tube. She had three HMPs – to address cardiac issues, hypothermia, and potential upper respiratory infections. The three HMPs were signed as reviewed by her nurse on 3/26/12, but the plans were not revised to reflect the significant changes in her condition. The plan to address hypothermia was not consistent with the statewide protocol or with the nurses' interventions documented in her record. In addition, her plan continued to call for warm liquids to be provided to her by mouth. The plan to address her potential URIs continued to reference her use of eating and drinking utensils. Finally, there were no plans in place that referenced nursing interventions to address one of her most salient health problems, needs, and risks – her gastrostomy, enteral feedings, and NPO status. • One individual, whose diagnoses included HIV+ received an "unconventional anti-retroviral medication regimen," at the time of his visit to the HIV clinic. His physician noted, "Today, I have no lab data..." and recommended, "Follow-up in six months with usual pre-clinic laboratory." This significant oversight was undoubtedly related to the fact that he had no HMPs to address his health care needs, including his needs associated with his high-risk conditions.	
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.	Of the six provisions of section M, M4 has the broadest scope. Since this provision item clearly ties assessment and reporting protocols to outcomes, it requires rigorous implementation to achieve substantial compliance. More specifically, this provision item demands that each component of the nursing process is in place and put into practice such that the health needs of the individuals served by the facility are met. This means that, when properly implemented, the assessment and reporting protocols should produce results, that is, produce expected outcomes. Expected outcomes will depend on the individual and his or her situation, and they may include maintaining or attaining health or achieving end of life goals. The CNE reported that, since the prior monitoring review, many steps were taken by the Nursing Department to achieve substantial compliance with this provision item. The monitoring team's review of a list of approximately 17 discrete activities, which were engaged in by the Nursing Department to conduct its self-assessment, revealed the following positive activities: • Ongoing and remedial education and training activities were underway to address nurses' practice and knowledge deficits, • Employment counseling sessions were occurring in an effort to help hold nurses accountable to meeting the requirements of their job and the standards of nursing practice,	Noncompliance

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		• Wound care, hospitalizations/discharges/transfers, and infection control protocols were being improved, expanded, and implemented, and • All recommendations made by the monitoring team during the prior review were addressed. Also, the results of the Program Compliance Nurse's analyses of self-assessment monitoring data were exceedingly positive and consistently revealed high scores of 88% to 94% compliance across several monitoring tools associated with this provision item. These data and their analyses also showed that when problems and/or deficiencies in practice were identified, corrective actions, as well as disciplinary actions, were planned and implemented. Thus, it was the opinion of the CNE and the Nursing Department at large that substantial compliance in M4 had been achieved. Without a doubt, the members of the Specialty Nurse team and the Quality Assurance Nurses were an experienced, dedicated, and hard-working group of nurses completely 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. The Program Compliance Nurse continued to systematically review nursing care, in accordance with the 12 monitoring tools, identify problems, and break down barriers to compliance. In addition, the Program Compliance Nurse ensured that all recommended corrective actions received follow-up to resolution and verified with Nurse Managers the outcomes of the actions. It was not unusual for the Program Compliance Nurse to spend hours on the units and attend unit-based Focus Meetings. Thus, she established herself as a resource for nurses looking for solutions to problems and answers to questions. According to the Program Compliance Nurse, she was beginning to see that "things were changing" for the better. In all the Program Compliance Nurse did, from monitoring to data analysis to establishing relationships with unit nurses, it was her goal to "keep the nurses motivated and moving forward toward compliance." As noted by the CNE, there continued to be expansion of initial and ongoing training and education of MSSLC's nurses and direct care staff members. During the monitoring team's interview with the Nurse Educator and Assistant Nurse Educator, it was reported that since the prior review, 16 assessment and reporting protocols were disseminated to all nurses. Also, all direct care staff members attended the Clinical Indicators course, which was made a part of all employees' annual re-training. This was another significant	

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		accomplishment by the Nursing Department and a strong step toward ensuring that individuals' health needs were addressed. As of the review, however, MSSLC was still not scheduled to receive the statewide nurse education initiative, which was specifically designed to help improve the capacity of the RN case managers and RN managers in the performance of nursing assessments. This continued to be much needed training session given the findings of problems in the accuracy and completion of the assessments reviewed in section M2. As described in the facility's self-assessment, since the prior monitoring review, a second Quality Assurance Nurse was added to the QA Department. However, although there were two Quality Assurance Nurses available to participate in all aspects of quality oversight of the delivery of health care services to individuals at MSSLC, their involvement and participation in the Nursing Departments ongoing quality assurance activities was much less than what was noted during prior visits and much more difficult to discern. Rather, it appeared that with the Nursing Department's addition of the Program Compliance Nurse, came the failure to involve or seek out the assistance and expertise of the Quality Assurance Nurses, who were trained and knowledgeable in program oversight, review, and analysis activities. They were also keen observers of systems' successes and failures, solutions and barriers. This finding was immediately shared with the Nursing Department and facility administration given its potential to negatively impact the facility's progress toward meeting the provisions of the Settlement Agreement. Of note, since the prior monitoring review, there were four deaths at the facility. For each individual, the QA Nurse completed a QA Death Review for Nursing. A review of these reports revealed that each and every review found numerous areas for improvement related to nurses' implementation of various assessment and reporting protocols, such as vital signs, preventive care, seizure management, acute illness and injury, care plan development, hospitalization/discharge/transfer, documentation, aspiration, urinary tract infection, and documentation. Given the gravity of the findings from the QA Death Reviews, the monitoring team, with assistance from the QA Nurse, conducted a brief onsite review of six randomly selected individuals with various health issues for evidence of (1) nurses' knowledge of the individuals' health issues, (2) nurses knowledge of the assessment and reporting protocols issued by state office and brief demonstration of the application of these assessment and reporting protocols, and (3) nurses completion and use of 24-hour shift reports and follow-up logs as evidence of effective reporting and communication of the individuals' health issues across shifts and among clinical professionals involved in the individuals' healthcare.	

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		The brief onsite monitoring review included interviews with seven nurses across six homes. The results of the brief interviews with the nurses assigned to the six individuals reviewed revealed exceedingly positive results. Every one (100%) of the nurses interviewed were knowledgeable of their assigned individual's health issues and reported same to the monitoring team; 100% of the nurses were aware of the assessment and reporting protocols (i.e., the laminated pocket-sized cards) issued by state office, and all nurses had their cards with them at the time of the review; and all nurses were able to show evidence of complete 24-hour shift reports and follow-up logs that reported and communicated the status of the individuals' health issues and directed the nurses to document follow-up notes of their assessments in the individuals' records. Thus, for all intents and purposes, there appeared to be evidence that systems and processes were in place to ensure nurses' implementation of assessment and reporting protocols sufficient to address the health status of the individuals served at MSSLC. Consequently, the monitoring team was also optimistic about the facility being rated in substantial compliance for section M4. Regrettably, however, the review of the 25 sample individuals' records failed to reveal that nurses properly implemented many of the assessment and reporting protocols for the majority of the individuals reviewed. These failures jeopardized the individuals' health and safety and placed them at risk of harm. As a result, a rating of noncompliance was given to this provision item. To reiterate, while onsite, the monitoring team was pleased to see the presence of a process of assessment and reporting. This was expressed to members of the Nursing Department. The subsequent review of records, however, showed that the status of <u>implementation</u> of the assessment and reporting protocols, and the resultant <u>outcomes</u> of implementation, were not yet in substantial compliance with this provision item. Almost all of the various assessment and reporting protocols referenced that, on the basis of an assessment, planned interventions should be documented and carried out. As noted above, it was striking to find that seven of the 25 individuals' records failed to have evidence of planned interventions to address their chronic and/or acute health care needs, and five of the 25 individuals' records had one or two health management plans filed in their records, but all had many pages missing from these plans. Across all 25 individuals, their records revealed the following: • Individuals with vomiting episodes failed to have implementation of the protocol developed to address this problem. Thus, some developed respiratory distress and others required emergency medical treatment. • Several individuals who suffered head injuries were not assessed or monitored,	

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		in accordance with the head injury protocol. This was especially significant for individuals who suffered "serious" head injuries and were not closely monitored. • Individuals with risks of hypothermia failed to have their core body temperatures confirmed and monitored by obtaining rectal temperature(s), in accordance with the hypothermia protocol and his/her physician's orders. • The enteral feedings of individuals who suffered episodes of wheezing, gurgling, and change in breath sounds were not stopped immediately and their physicians were not notified, in accordance with the enteral feeding protocol. • Individuals who suffered episodes constipation were not assessed or monitored, in accordance with the constipation protocol. • Individuals who suffered acute illness/injuries were not assessed, monitored, and evaluated for their response(s) to treatment until their illness/injuries resolved, in accordance with the protocol. • The SOAP documentation protocol's requirements for formulation of planned interventions specifically related to the identified problem, including documentation of what the nurse did and what he/she planned to do to correct/alleviate the problem were consistently unmet.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	At the time of the monitoring review, MSSLC had completed the first year of its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the ISP process. According to the facility's self-assessment, since the prior monitoring review, "although the scores of the [monitoring tools] reflect a high percentage [of compliance], it is felt the data is unreliable...for this reason alone, this provision is not in substantial compliance." The monitoring team agreed with the facility's self-rating of noncompliance. However, the monitoring team's rating was based upon findings that indicated that the facility had not fully developed or implemented an adequate system of assessing, documenting, developing, evaluating, monitoring, and re-evaluating health risks and integrated risk action plans for each individual, as indicated by the health status of the individual. For example, as recent as 3/15/12, the Nursing Department assigned "at-risk" duties to the new Skin Integrity Nurse. During the monitoring team's interview with the Skin Integrity/At Risk Nurse, it was revealed that she was not versed in the expectations of her new position or how she might proceed with helping teams across the facility evaluate individuals' health risks and develop appropriate action plans. Indeed, it was a surprise to all (facility staff and monitoring team members), when it was announced on 3/28/12 that, at MSSLC, "RN case managers will be responsible for putting all data input into a narrative, paragraph form for the team prior to the IDT meeting," and "[RN case managers] will be responsible for ensuring that the collaboratively developed risk	Noncompliance

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		assessments and risk action plans are completed, documented, and implemented..." The outcomes of these changes loom large, especially since RN case managers already play a big part in helping the facility achieve substantial compliance in provisions M1 through M4. During the conduct of the review, the monitoring team attended one ISP meeting, which was held on behalf of Individual #597 and conducted prior to the changes in the at-risk process and assignment of additional responsibilities to the RN case manager. The QDDP who chaired the meeting was very well prepared and had all of the skills needed to keep the meeting participants focused and engaged in the process. This was especially observed and appreciated when the individual's health risks were discussed. The review and assignment of health risks was seamlessly integrated into the team's review and discussion of other important aspects of the individual's life. All relevant team members, including her physician and other clinical professionals, attended the ISP meeting, there were very good discussions of Individual #597's relevant history, her current functioning, and her desired outcomes/goals for more independent living in a more integrated setting. All of the discussions, in appropriate ways, segued into and out of the review of Individual #597's health risks. The conduct of the RN case manager who participated in the ISP meeting was exemplary. The RN case manager was well informed and offered to the team well-formulated opinions regarding the individual's level of risk for particular areas of her health status and ideas for ways in which the individual's health risks might be better addressed and reduced while respecting her choices and preferences. It was apparent that MSSLC had taken steps to ensure that its program staff members and clinical professionals were aware of the expectations that they must come to the ISP meetings prepared and knowledgeable of all of the individual's relevant health risk information within the scope of their job duties and practice, actively participate in identifying level of health risk(s), and collaboratively develop action plans that reduce the risk of negative health outcomes. Notwithstanding these positive findings, during the review of the 25 sample individuals' records, a pattern of problems ensuring full and consistent implementation of the risk assessment and planning processes emerged. All 25 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and several individuals' physicians referred to them as having one or more high health risks. However, of the 25 sample individuals whose records were reviewed, two failed to have current ISPs, including a baseline risk assessment. Also, a	

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		review of the 23 individuals who had an, at least, annual health risk assessment filed in their record, revealed that almost half of them (11) failed to have their levels of risk appropriately and consistently revised when significant changes in individuals' health status and needs occurred. Rather, it was not until the individuals suffered actual (versus risk of) negative health outcomes that levels of risk were revised and appropriately raised. Examples included the following: • Individual #562 was a 51-year-old man with severe tremors of all of his extremities. Despite his tremors, high risk of fractures, and actual falls, including a fall on 12/29/11 that resulted in serious injuries, during his 2/29/12 ISP meeting, his team reviewed his falls, injuries, fractures, and tremors, and "agreed that he was at low risk for falls." • Individual #135 was a 66-year-old man diagnosed chronic health problems, which included "toe walker with history of falls." On 11/7/11, Individual #135's physician wrote an order to added the diagnosis of "high risk of falls" to his current, active problem list, but his fall risk was not revised. On 1/30/12, Individual #135 fell and sustained a serious head injury. On 2/23/12, his team met for his first quarterly meeting. During Individual #135's team's discussion of his health risks they noted that he "had several falls this quarter," "a nursing care plan for injuries and abnormal body movement," and "a recent serious injury related to a fall." Even so, "The team agreed to continue the medium risk for falls." • An individual diagnosed with chronic health problems, which included chronic HIV+, was rated at low risk for the majority of the health risks, including "Infections." The team's rationale for the low rating was "immune system not compromised."	
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	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 additional 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 improving nursing procedures for the administration of medications and identifying and measuring the nature, severity, and scope of their problems in this area. For example, since the prior monitoring review, the policy guiding and directing nurses administration of medications was revised to clarify expectations for the timeframes when administering "stat," "now," and routinely ordered medication(s). Nurses were	Noncompliance

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	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.	also re-trained on the state policy governing the enteral administration of medications and were provided additional education regarding infection control and prevention during medication administration. This provision item, however, was rated as being in noncompliance because there continued to be problems in the systems of medication accountability and reconciliation and additional work that needed to be done to completely re-establish the Medication Error Review Committee. Observations of medication administration, both oral and, when appropriate, enteral, were conducted on Martin 3, Martin 5, Barnett 7, Barnett 8, Central 7, and Longhorn 6. During all five observations, nurses administered medications in accordance with current, generally accepted standards of care. Nurses properly followed infection control practices, treated individuals with respect and dignity, and implemented at least some, if not all, steps of individuals' SAM programs. These findings were indicative of significant improvements in performance from that of prior reviews. The review of the 25 sample individuals' current MARs for the period of 3/1/12 to 3/30/12 revealed many fewer omissions and/or discrepancies in the MARs of the individuals reviewed than what was noted during prior reviews. There were only five individuals' MARs where omissions and discrepancies in entries for medications and treatments were noted. However, there continued to be problems with proper and complete documentation of the implementation of SAM programs. Approximately half (12) of the 25 sample individuals reviewed failed to have evidence that their SAMs were implemented as planned. During the week of the onsite review, the monitoring team attended the meeting of the Medication Error Committee, which was chaired by the Chief Nurse Executive. This was only the third meeting of the committee since the responsibility for the management and review of medication variance data were transitioned to the Nursing Department. During this meeting, the numbers of medication errors over the past six months were reviewed, and various possible correlates to the errors, such as location, staffing data, discipline, and shift were discussed. However, no data from the Pharmacy Department's reconciliation of medications returned to the pharmacy were presented. Thus, when the monitoring team asked the committee to estimate how many medications were returned to the pharmacy on a monthly basis, they were unable to do so. Also, there were no lists, tables, spreadsheets, etc. available for review and discussion by the committee members for (1) the type of variances, (2) that occurred on particular days at particular times, and (3) involved which individuals and what medications. Thus, it was only in response to several questions posed by the monitoring team that the	

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		Pharmacy Department clarified that, contrary to the Nursing Department's self-assessment, which stated under provision M6 that they were "able to come to complete reconciliation of every pill and liquid for the past several months," only the non-stock, pill-form medications were currently being reconciled. During a discussion of the committee's analyses and reporting of medication errors, several concerns were raised by the monitoring team members for the committee to consider. These are repeated below: • There continued to be no systems in place to reconcile medications that were in the form of stock and/or non-pill form. • The data presented to the Committee failed to include the Pharmacy Department's reconciliation data/information. • The committee had not met its obligation to analyze, track, and trend medication variances and closely follow its recommendations through to completion. • Also, the committee continued to need to work on developing its systemic focus. • In addition, the committee had not yet made certain that its findings and recommendations were reported to the Pharmacy and Therapeutics Committee on a quarterly basis. • The concept of an adverse drug reaction was apparently not well understood by some clinical professionals, including nurses. For example, it was not apparent whether or not some clinical professionals, including nurses, were knowledgeable of what constituted an ADR, what to do when you believed an individual was suffering an ADR, how to report an ADR, and what came after a suspected ADR was identified and reported.	

Recommendations:

1. Consider devoting some of the time currently spent conducting retrospective record reviews and auditing using monitoring tools to performing activities to validate the effectiveness of corrective actions and conducting mentoring activities that result in real-time corrections of problems, especially those problems associated with nurses' implementation of assessment and reporting protocols (M4).

2. Consider changing some of the ways the monitoring tool data is analyzed and presented for purposes of the facility's internal QA and program compliance monitoring and strategic planning for improvements to achieve substantial compliance with the provisions of Section M (M1-M6).

3. Re-establish effective collaboration and coordination of oversight activities and improve communication between the Nursing and Quality Assurance Departments (M1).

4. 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).

5. Ensure that individuals have planned interventions vis a vis Health Management Plans/Acute Care Plans to address all of their current health needs (M1, M3, M4, M5).

6. Improve the timeliness of regularly scheduled comprehensive nursing assessments, such as admission and quarterly nursing assessments (M2).

7. Improve the timeliness and adequacy of Nursing Department's response to the QI Death Reviews for Nursing, which appear to identify problems that are consistently identified during other QA reviews and program compliance monitoring activities (M1-M6).

8. 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).

9. 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).

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

11. Collaborate with the Pharmacy Department to develop systems to reconcile medications that are dispensed in stock/bulk quantities and/or non-pill form (M6).

12. Communicate and clarify the expectations and job duties of the Skin Integrity/At-Risk Nurse, especially in light of the recent changes in the at-risk process at MSSLC (M1, 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:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.1: Medical Care, 2/16/11 o DADS Policy #011: Pharmacy Services, 9/26/11 o DADS Policy #053: Medication Variances, 9/23/11 o MSSLC Self-Assessment for Section N o MSSLC Action Plan for Section N o MSSLC Organizational Charts o MSSLC Medical Services – 25 Safe Medication Practices, 2/18/11 o MSSLC Medical Services -22: Adverse Drug Reaction Reporting, 2/17/11 o MSSLC Policy and Procedure, Medical #20, Monitoring Clozapine 10/7/11 o MSSLC Lab Procedure Matrix, revised 11/16/11 o MSSLC Policy and Procedure: Drug Utilization Evaluations 4/18/11 o MSSLC Nursing Services - 68, DISCUS and MOSES Screening, July 1, 2010 o MSSLC Pharmacy Policy & Procedure Manual, # 46.1, Reviewing Physician Orders 9/26/11 o MSSLC Pharmacy Policy and Procedure Manual, Pharmacy No. 46.2, Performing Clinical Interventions, 9/26/11 o Pharmacy and Therapeutics Committee Summary of Meeting, 9/22/11, 12/19/11 o Medication Error Review Committee Meeting Minutes: 1/30/12, 2/23/12 o Psychoactive Medication Polypharmacy Review Committee Meeting Minutes, 9/22/11, 10/7/11,10/14/11,10/21/11,11/29/11,12/22/11,1/26/12,1/30/12 o PET II Meeting Minutes o Clinical Intervention Forms, September 2011 – February 2012 o Review of Physician Order Forms, September 2011 – February 2012 o Adverse Drug Reactions Quarterly Summary Logs: April 2011 – August 2011 o Summary Logs for Single Patient Interventions and Review of Physician Orders o Medical Review Committee Summaries: September 2011 – March 2012 o Daily Clinical Services Meeting Notes, August 2011 – January 2012 o Adverse Drug Reactions Reports, September 2011 – February 2012 o Drug Utilization Evaluation – Clozapine, 12/19/11 o Drug Utilization Evaluation – Phenobarbital, 3/28/12 o Quarterly Drug Regimen Reviews for the following individuals: • Individual #394, Individual #141, Individual #575, Individual #349, Individual #67, Individual #426, Individual #592, Individual #436, Individual #558, Individual #123, Individual #375, Individual #133, Individual #143, Individual #474, Individual #407, Individual #197, Individual #435, Individual #395, Individual #557, Individual #335, Individual #306, Individual #446, Individual #583, Individual #8, Individual #386,

	Individual #554, Individual #539, Individual #113, Individual #350, Individual #320, Individual #127, Individual #431, Individual #31, Individual #121, Individual #225, Individual #414 Individual #485 o MOSES evaluations for the following individuals: • Individual #380, Individual #426, Individual #92, Individual #270, Individual #389, Individual #434, Individual #592, Individual #141, Individual #244, Individual #58, Individual #113, Individual #590, Individual #350, Individual #429, Individual #45, Individual #267, Individual #386, Individual #10, Individual #583, Individual #183, Individual #287, Individual #6, Individual #261, Individual #254, Individual #393, Individual #568, Individual #198, Individual #169, Individual #300, Individual #264 Individual #170, Individual #414, Individual #71, Individual #508, Individual #535, Individual #54, Individual #159, Individual #199, Individual #194, Individual #109, Individual #304, Individual #600, Individual #29, Individual #65, Individual #229, Individual #265, Individual #342, Individual #276, Individual #283, Individual #510 o DISCUS evaluations for the following individuals: • Individual #380, Individual #426, Individual #92, Individual #270, Individual #389, Individual #434, Individual #592, Individual #141, Individual #244, Individual #58, Individual #113, Individual #590, Individual #350, Individual #429, Individual #45, Individual #267, Individual #386, Individual #10, Individual #583, Individual #183, Individual #287, Individual #6, Individual #261, Individual #254, Individual #393, Individual #568, Individual #198, Individual #169, Individual #300, Individual #264 Individual #170, Individual #414, Individual #71, Individual #508, Individual #535, Individual #54, Individual #159, Individual #199, Individual #194, Individual #109, Individual #304, Individual #600, Individual #29, Individual #65, Individual #229, Individual #265, Individual #342, Individual #276, Individual #283, Individual #510 <u>Interviews and Meetings Held</u>: o Anyssa Garza, Pharm.D, Pharmacy Director o Abigail Okeke, Pharm.D, Clinical Pharmacist o Dolores Erfe, MD, Medical Director o Norris Buchmeyer, Chief Nurse Executive o Karen Wilson RN, QA Nurse o Angela Johnson, RN, Medical Compliance Nurse <u>Observations Conducted</u>: o Pharmacy and Therapeutics Committee Meeting o Medication Error Committee Meeting o Polypharmacy Committee Meeting o Medical Review Committee Meeting o Daily Clinical Services Meeting o PET II Meeting o Pharmacy Department

	Facility Self-Assessment: MSSLC updated its self-assessment on 2/21/12. The self-assessment was now independent document. The facility also utilized two other documents as part of the overall assessment and guidance process: the action plan and actions completed. For the self-assessment, the facility descried for each of the eight provision items, a series of activities engaged in to conduct the self -assessment, the results of the self-assessment, and a self-rating. This was a great improvement in the assessment process. During the week of the onsite review, the monitoring team had the opportunity to discuss the self-assessment process with staff. Although most staff did not fully understand the process, all were eager to learn what was needed to assess their areas so that they could move forward in achieving substantial compliance. To take this process forward, the monitoring team recommends that the pharmacy director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in substantial compliance with provisions N1, N2, and N7. It rated itself in noncompliance with provisions N3, N4, N5, N6, and, N8. The monitoring team found noncompliance for all provision items.
	Summary of Monitor's Assessment: Each of the four compliance visits was marked by the leadership of a different pharmacy director. The newest director was hired in September 2011. The pharmacy department was fully staffed at the time of the review with a pharmacy director, three pharmacists, and four pharmacy technicians. A staff pharmacist retired in January 2012 and the position was filled with a contract clinical pharmacist while the pharmacy 2 position was recruited. The frequent change at the director level prevented the type of gains in momentum that were needed to move towards substantial compliance with the Settlement Agreement. Nonetheless, progress was noted, but was subdued by an apparent lack of awareness of all that the actions that needed to occur. This was not necessarily a reflection on the pharmacy director, but more likely reflected a culture of frequent change in leadership and a director who was both a new graduate and a new employee.

	Many issues that were noted in the September 2011 report had not been addressed or were addressed immediately prior to the review. Although the state issued the pharmacy operations policy in September 2011, the facility did not draft a local version until 3/15/12. Important practices related to procedures, such as the drug regimen reviews, were implemented, but the policies were not formally revised. Other areas impacted by the Settlement Agreement underwent changes without having the appropriate changes in policy and procedure. The procedures for communicating with prescriber were clarified and documentation improved. It was also noted that improvement was needed in the area of the pharmacists reviewing orders relative to the need for lab monitoring. A Clozaril protocol was developed and implemented and that was good to see. The drug regimen reviews presented many challenges both in the content and in terms of physician review. The clinical pharmacist provided some good information, but additional work was needed. There were serious delays in the completion of the physician reviews and the etiology of those delays was not clear, but corrective actions were implemented. The completion of the MOSES and DISCUS evaluations also presented challenges in terms of nursing completion and physicians review. Corrective action plans were implemented to address these deficiencies as well. ADR reporting increased since the last visit, but reporting continued to be completed largely by the clinical pharmacist. The facility had not implemented training for the clinical staff and those with significant contact with the individuals. DUEs were completed on a quarterly basis, but the vastness of each DUE reduced its clinical relevance for the facility. The facility continued to report medication variances including pharmacy and prescribing errors. As the system captured variances that occurred within more disciplines, there was a failure to ensure that all medications were reconciled. Finally, based on the observation of one meeting, it appeared that the Pharmacy and Therapeutics Committee functioned in a very limited capacity. There was no agenda. A "Summary of Meeting" document was provided at the beginning of the meeting. It included the discussion and disposition of the topics. The pharmacy director read the information for each topic. This format resulted in a lack of a robust discussion. This was unfortunate because this committee provided oversight and guidance for many processes including DUEs, medication variances, adverse drug reactions, QDRRs, medication formulary, and all other matters related to medication practices for the facility. This quarterly meeting lasted 48 minutes. It would be unlikely that the required topics could occur on a quarterly basis in an appropriate manner in 48 minutes.

<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>This provision item is related to fundamental components of the medication use system – the prescribing and dispensing of medications. A prospective review was completed for all new orders through the WORx software program. The program checked a number of parameters, such as therapeutic duplication, drug interactions, allergies, and other issues.

The pharmacy department formally implemented two new procedures: clinical interventions and review of physician orders. The clinical interventions procedure specified the parameters to be reviewed, required the pharmacist contact the physician, document on, and sign the clinical interventions form. The procedure did not specify a requirement for the physician to review and sign the form, but the form included a place for a physician signature.

The monitoring team requested copies of all Single Patient Interventions and Notes Extracts completed since the last onsite review. Clinical Intervention Forms were submitted along with the Notes Extracts. The Review of Physician Order Forms were not submitted, but should have been because they represented documentation of the interactions between pharmacists and prescribers during the prospective review. Summary data are represented in the chart below.

<table>
<tr><td colspan="7">Physician Orders 2011-2012</td></tr>
<tr><td></td><td>Sep*</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td></tr>
<tr><td>Clinical Intervention</td><td>2</td><td>8</td><td>11</td><td>12</td><td>13</td><td>5</td></tr>
<tr><td>Review of Physician Orders</td><td>9</td><td>43</td><td>17</td><td>3</td><td>6</td><td>5</td></tr>
<tr><td>Total</td><td>11</td><td>51</td><td>28</td><td>15</td><td>19</td><td>10</td></tr>
</table>
*Incomplete month

The clinical intervention log documented the types of recommendations made to the prescribers, the responses of the prescribers, and the outcomes. The review of physician orders log provided information on the medications, the order issues, method of communication with prescribers, prescriber responses, and outcomes. The data provided indicated that there were, on average, .5 clinical interventions per day. That would appear to be an unusually low number for a facility with a census of 390.

Although these processes documented that the pharmacists contacted the prescribers, a review of the summary logs and forms indicated that there were problems with the current processes. The following are several concerns identified by the monitoring team:
• There was no documentation that the changes accepted by clinicians were actually completed.
• The process for management of severe drug interactions did not differ from the</td><td>Noncompliance</td></tr>
</table>

		management of mild interactions. The pharmacy director indicated that management of the various levels of drug interactions was not specified in policy and procedure. The need for improvement in this area was noted in the September 2011 review. • Even with the implementation of a clozapine protocol, there continued to be issues related to clozapine monitoring. Several clinical interventions were related to a lack of appropriate lab monitoring. The pharmacy director generated numerous emails related to this issue. The minutes of the Medical Review Committee documented that there was a monthly discussion related to clinical intervention/physician order data. The minutes did not provide any information, analysis of data, or outcomes of the discussions. For example, the data indicated that the greatest number of clinical interventions was related to the issue of laboratory monitoring. The minutes did not include any information on the causes of the problems or what corrective actions were taken to correct the problems. Similarly, review of the physician orders data indicated that most order problems involved a lack of stop dates, routes of administration, and indications, but the minutes did not capture what, if anything, was done to address the issue. The decrease in numbers, however, would appear to indicate that some action occurred. The medical director should track this data, analyze it, and use it to develop corrective actions and training opportunities for the medical staff. When individuals are prescribed medications to which they are known to have allergies, the matter should be reviewed to determine the existence of human or systemic error. Patterns regarding incomplete, incorrect, and vague orders should be addressed with the medical staff. Finally, this provision item required "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… the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." During discussions with the pharmacy director, she indicated that starting in February 2012, pharmacists had access to lab values in the WORx system. Moreover, she reported that she personally checked lab values that required monitoring, but other pharmacists did not always do so and current policy did not require this. The monitoring team believes that the number of clinical interventions will likely <u>increase</u> when all pharmacists are consistently applying the monitoring parameters during the prospective reviews. In order to achieve substantial compliance with this provision item, there will need to be a consensus on the requirements for checking lab values prior to dispensing medications. That is, the pharmacy and medical departments will need to develop a list of medications that will require documentation of labs prior to dispensing. The facility will need to seek	

		guidance from state office on this important matter.	
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.	A total of 52 Quarterly Drug Regimens Reviews were evaluated to determine compliance with this provision item. In accordance with state policy, the QDRRs included reviews of allergies, the appropriateness of medications, rationale for therapy, proper utilization, duplication of therapy, polypharmacy, drug – drug/food/disease interactions, and adverse reaction potential. The facility had adopted the lab matrix as the set of monitoring parameters for drug use. This required monitoring related to labs, vital signs, and other diagnostics associated with drug use. The current Drug Regimen Review Policy, adopted in February 2011, required quarterly completion of drug regimen reviews. Primary providers and psychiatrists were required to review the documents. No additional timelines were provided in policy. The QDRR schedule did not include the schedule for each individual but listed, by quarter, each home, and the month that QDRRs for that home would be completed. The pharmacy director provided an undated document that described a new process for completing drug regimen reviews. It was reported that the QAQI Council approved this procedure, but the QDRR policy was not revised to reflect such changes. It appeared from the N2 action plan that the new procedure was implemented in January 2012. The change in process appeared to be a response to a serious lapse in timelines for review. This is discussed in further detail in section N4. Based on the dates provided on the QDRRs they appear to have been completed by the clinical pharmacists in a timely manner. Lab values were usually noted in the comments section and documentation improved since the September 2011 visit. Monitoring parameters were not consistently cited in the comments section, though usually, but not always, they could be located in the worksheets. The reviews provided some good information, but the monitoring team identified several problems related to content and processes: • Only 23 of 52 (43%) of QDRRs included formal recommendations by the clinical pharmacists. • Many QDRRs had recommendations in the comment section. This finding was also noted by the medical department's monthly SAMT audits. • The QDRRs for individuals who received lithium frequently lacked documentation of the results of urinalysis and EKGs. • The QDRRs did not comment on EKGs and eye exams for those receiving quetiapine. • Documentation of EKGs and UAs were not found for several individuals treated with antihypertensives. • Monitoring for individuals with diabetes mellitus was either lacking or incomplete.	Noncompliance

		• There were inappropriate indications that were not questioned by the pharmacist. • The anticholinergic burden of each drug was listed separately and there was never any guidance given on how to decrease that burden. • There were no comments on polypharmacy other than it existed. • Several QDRRs indicated major drug interactions. Those documents did not indicate that the PCP had been notified of a severe drug interaction. • There were several QDRRs where the MOSES and DISCUS evaluations were not done and a request or recommendation to have them completed was made, but noted in the comments section only. • Several comments lacked clarity and/or clinical relevance such citing CBC as a parameter for GERD. A few example of issues identified in the QDRR sample are presented below. Individual #394, 12/28/11 • There was no documentation of a urinalysis for lithium use and no comments by the clinical pharmacist. Individual #141, 12/28/11 • There was no documentation of an EKG or urinalysis for lithium use and no comment by the clinical pharmacist. Individual #197, 11/16/11 • There was no documentation of an EKG or eye exam for Seroquel use and no comments by the clinical pharmacist. Individual #375, 12/27/11 • The clinical relevance of this statement was not clear: "R/O cardiac complications: See CBC above." Individual #518, 11/17/11 • There was no documentation of any monitoring for the use of diabetic medications • The individual received Haldol and lorazepam for the indication "prevention of removal of feeding tube." The benzodiazepine section indicated the psychiatrist notes appropriately justified the use of this agent. The psychiatrist documented there were no drugs used by psychiatry. • The clinical pharmacist did not question the indication for use of these medications.	

		Individual #414, 12/10/11 • The clinical pharmacist commented on glucose and HbA1c, but did not mention the other important parameters for diabetes monitoring, such renal function including urine microalbumin. There was also no mention of eye or podiatry exams. • The QDRR also documented "Health care management plan: stool softener and docusate sodium." It would be preferable to state that there was a plan for constipation. The pharmacy director must revise the QDRR policy and address several issues: • The timelines for completion of the QDRRs by the pharmacist based on state guidelines for the 90 day completion. • The process for completion by the medical providers including the timeframes for completion. • The new electronic process for completion of the QDRRs should be included in the QDRR policy. • All staff should receive training on the process.	
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 five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication</u> The use of stat and emergency medications was beginning to be discussed in the weekly Medical Review Committee meeting and documented in the minutes. Additional discussion was also occurring during the Polypharmacy Committee meetings. The use of stat and prn medication is discussed further in Section J. <u>Polypharmacy</u> The presence or absence of polypharmacy was noted in every QDRR reviewed and that was the extent of the comments. Psychotropic polypharmacy was discussed monthly in the Psychotropic Polypharmacy Committee meeting. With regards to psychotropic polypharmacy, these data were of little use because it represented absolute polypharmacy and not relative use. That is, the facility did not have data on the total number of individuals receiving psychotropics in order to calculate actual meaningful polypharmacy data. Psychotropic polypharmacy is discussed further is Section J. <u>Benzodiazepine Use</u> Benzodiazepine use was recorded when appropriate. The usual indication was prn seizure activity. As noted in Section N2, one individual was noted to receive lorazepam to "prevent pulling tube out." That individual did not appear to be followed by psychiatry.	Noncompliance

		Anticholinergic Monitoring Anticholinergic burden was recorded in the QDRRs when appropriate. Each drug had its anticholinergic burden listed separately. There were no recommendations given with regards to how to minimize this risk. The information would appear to have little clinical relevance. Monitoring Metabolic and Endocrine Risk The clinical pharmacists consistently recorded the monitoring parameters associated with the use of the new generation antipsychotic agents. The QDRRs were noted to include weights, BMIs, lipids, blood glucoses, and sometimes HbA1cs. Blood pressures and abdominal girths were not consistently noted. Data provided in a longitudinal manner would prove even more beneficial to clinicians. It would also be helpful to indicate the changes in weights or BMIs.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the provider's responses to both prospective and retrospective reviews. As discussed in Section N1, the facility did not provide evidence that changes accepted were actually completed. For this review, compliance with this provision item was assessed based on information related to the Quarterly Drug Regimen Reviews and, as indicated below, the facility did not maintain performance and, therefore, did not maintain substantial compliance with this provision item. There were problems with the drug regimen review process: • There were marked delays in getting the reviews to the medical staff. This was evident in the sample submitted by the facility, but the records audits showed even greater problems with delays of up to two months or more before the final psychiatric review was completed. Some medical providers made comments on the forms related to the tardiness of receipt of the reviews. • 35 of 52 (67%) of the QDRRs assessed involved the use of psychotropics. Only 13 of 35 (37%) were reviewed by the psychiatrists. The monitoring team was concerned about this finding because there was information in the QDRR comments that required psychiatry review. A sample of 36 QDRRs submitted by the facility, in addition to 16 QDRRs included in the record sample, were evaluated. For the QDRRs reviewed as part of the record sample, there were 15 medical recommendations and the following responses were noted: • 6 of 15 (40%) recommendations were accepted by the PCP • 6 of 15 (40%) recommendations were rejected by the PCP • 3 of 15 (20%) recommendations were left blank (did not agree, disagree, or state NA)	Noncompliance

		The PCP documented the reasons for disagreement on the QDRR. For Individual #65, the labs and eye exam were not actually completed at the time of the QDRR, so the pharmacist made the appropriate recommendation. The recommendation to implement low dose ASA for Individual #542 was rejected due to "no indication." Full dose ASA was started several weeks later after the occurrence of a significant cardiovascular event. For the same sample of QDRRs, there were 11 recommendations regarding the use of psychotropic agents: • 5 of 11 (45%) recommendations were accepted by the psychiatrist • 4 of 11 (36%) recommendations were rejected by the psychiatrist • 1 of 11 (9%) recommendations was not reviewed by the psychiatrist • 1 of 11 (9%) recommendations was left blank by the psychiatrist (did not agree, disagree, or state NA) Documentation of the reasons for disagreement was made on the QDRR forms that were part of the permanent record. The deficiencies in this process appeared to be well known and documented by the facility. The medical provider quality audits scored low compliance rates in this area, as did the monthly medical audits. The monitoring team noted several responses to these audits from the medical staff that indicated that receipt of the QDRRs was problematic. Discussions with the pharmacy director alluded to problems with physician completion of the reviews. Nonetheless, corrective actions had been taken to address the problem. As discussed in section N2, a new electronic QDRR process was implemented in January 2012. This process would make the reviews available to the physicians immediately for response and would allow the clinical pharmacist to track the responses. Physicians were also given a 10 day window to complete the review. The process of conducting drug regimen reviews and responding to the recommendations of the reviews is one of the most important aspects of safe medication practices. It is worthy of the appropriate attention from the pharmacy and medical practitioners. Many individuals supported by the facility had complicated drug regimens capable of resulting in serious side effects and adverse drug reactions. Completing reviews, transferring information, and responding to information in a timely manner is important. The monitoring team recommends that the new electronic process be reviewed to ensure that the goals of accountability will be achieved. The clinical pharmacists and medical staff must be held accountable for completion of the process in accordance with state guidelines. This process must also become a part of the facility's drug regimen review policy and procedure and, therefore, must go through the full policy review process.	

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.	A sample of the most recent MOSES and DISCUS evaluations submitted by the facility in addition to the most recent evaluations included in the active records of the record sample was reviewed. The findings are summarized below: Fourteen MOSES evaluations included in the record sample were reviewed for timeliness and completion: • 13 of 14 (93%) were signed and dated by the physician • 7 of 14 (50%) documented no action necessary • 6 of 14 (43%) documented no conclusion under the prescriber review • 1 of 14 (7%) documented 14 days or more between examination date and physician review date Twelve DISCUS evaluations included in the record sample were reviewed for timelines and completion: • 11 of 12 (92%) were signed and dated by physician • 6 of 12 (50%) indicated the absence of TD • 3 of 12 (25%) indicated the presence of TD • 3 of 12 (25%) documented no prescriber conclusion • 2 of 12 (17%) documented 14 days or more between examination date and physician review date Forty MOSES evaluations submitted by the facility were reviewed for timeliness and completion: • 39 of 40 (98%) were signed and dated by the physician • 29 of 40 (73%) documented no action necessary • 11 of 40 (27%) documented no conclusion under the prescriber review • 8 of 40 (20%) documented 14 days or more between examination date and physician review date Thirty-nine DISCUS evaluations submitted by the facility were reviewed for timeliness and completion: • 33 of 39 (84%) were signed and dated by physician • 33 of 39 (84%) indicated the absence of TD • 2 of 39 (5%) indicated the presence of TD • 4 of 39 (10%) documented no prescriber conclusion • 7 of 39 (18%) documented 14 days or more between examination date and physician review date The data indicated that physicians were not adequately completing the prescriber conclusion as required. While the dates on the evaluations indicated timely completion by nursing, numerous facility audits documented low compliance scores for nursing's	Noncompliance

		compliance with timelines for completion. SAMT monitoring compliance rates for November 2011, December 2011, January 2012, and February 2012 were 50%, 60%, 20%, and 60% respectively. This resulted in implementation of a corrective action plan. The MOSES evaluation was completed every six months while the DISCUS evaluation was required every three months. The facility policy required the psychiatrist review the DISCUS, but did not define which prescriber was responsible for review of the MOSES evaluation. While completion by the medical staff improved since the last visit, a significant number of evaluations failed to be properly completed. It might be helpful to define in policy the responsibility for completion of both documents. It is also important to ensure that all staff receive appropriate training. The clinical significance of the identification of the development or presence of extrapyramidal symptoms and the potentially irreversible tardive dyskinesia requires that staff be vigilant in completing these reviews. This information should be provided to the neurology consultants for review. It is also important that the primary care physicians review this information and consider including it in their annual and quarterly assessments.	
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 report ADRs. From September 2011 to January 2012, 78 ADRs were reported. The reactions were discussed in the Pharmacy and Therapeutics Committee meetings. The pharmacy director tracked data. ADR forms from September 2011 – January 2012 were reviewed. Of the 78 forms reviewed, nine (12%) were submitted by two members of the medical staff. These nine forms were completed. The remaining 69 were not. The sections that categorized the severity level and outcomes were usually incomplete. Information related to reaction abatement and drug re-challenging was usually missing. Completion of the probability scale required an answer to these questions. During the onsite review, the monitoring team attended the Pharmacy and Therapeutics Committee meeting and noted the ADR presentation was simply a quick reading of the summary data with no discussion. There was no follow-up of previous ADRS. While the P&T Committee meeting would not allow for the discussion of every ADR, the committee needed additional information on the types and numbers of ADRs that occurred. The pharmacy director reported that direct care professionals received training related to adverse drug reactions through the clinical indicators training. There was no specific ADR training developed for direct care professionals or any of the clinical staff. It was also stated that one barrier in development of an effective system was the lack of physician participation in the process. The self –assessment clearly stated that physicians needed to report ADRs and complete the forms to ensure that data could be used to take necessary corrective actions.	Noncompliance

		Several recommendations were made in the September 2011 report including: (1) revision of the ADR policy and reporting form to reflect the addition of the Naranjo probability scale, (2) development of a mechanism for completion of an intense case analysis, and (3) provision of training on recognition and reporting of adverse drug reactions to those with significant contact with the individuals. At the time of this review, none of the recommendations had actually been completed. A revised ADR form had not been approved and implemented. A risk probability scale was added to an older ADR policy, but there was no approved version of this policy. There was no format for completing an intense case analysis. In fact, the December 2011 Pharmacy and Therapeutics Committee minutes indicated that an individual receiving Keppra crossed the threshold for review based on a risk probability number of 24. There was no documentation that a review was completed and the March 2012 meeting did not include any discussion of an intense case analysis. Had such an analysis been completed, a report should have been presented to the committee. Finally, there had been no progress in developing training for staff. The clinical pharmacist completed the majority of the ADR forms during the conduct of QDRRs. A fully implemented ADR reporting and monitoring system mandates that all healthcare professionals and others with extensive contact with the individuals have the ability to recognize and report adverse drug reactions. The facility must ensure that all medical providers, pharmacists, nurses, respiratory therapists, and direct care professionals receive appropriate training on the recognition of ADRs and the facility's reporting process. Documentation of this training should be maintained.	
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.	DUE reports on clozapine and phenobarbital were provided for review. Both reports included background information, objectives, criteria, methods results, conclusions, and recommendations. During the conduct of the evaluations, primary care physicians, psychiatrists, and clinical pharmacists were assigned to retrieve and review data. Data collection forms were forwarded to the pharmacy director who generated a summary report. The findings were presented to the Pharmacy and Therapeutics Committee meeting. <u>Clozapine</u> The objective was to assure appropriateness, safety, and effectiveness of clozapine through monitoring, assessing for possible adverse drug reactions, and providing recommendations. Data collection forms were developed based on the Texas drug audit criteria and facility monitoring protocols used to assess justification of drug use, contraindications, monitoring, and dose. The audit tool consisted of 21 questions. The 10 individuals who received the drug were evaluated. The overall compliance for justification, contraindications, monitoring, and dosing were 90%, 80%, 90%, and 100% respectively.	Noncompliance

		The DUE was presented to the Pharmacy and Therapeutics Committee on 12/19/11. Recommendations included the need to continue to monitor these individuals in a collaborative manner and follow-up with those individuals who did not have 100% compliance scores. <u>Phenobarbital</u> According to the report, the "DUE was designed and put in place to assure the appropriateness, safety, and effectiveness of Phenobarbital." This included evaluation of monitoring, assessing for ADRs, and providing needed recommendations. Sixteen individuals who received Pb were assessed for 19 criteria based on the drug label information. All physicians and the clinical pharmacist completed the audits. The pharmacy director compiled the information. The overall compliance for justification, contraindications, monitoring, and dosing were 100%, 95%, 99%, and 100% respectively. The average overall individual compliance score was 90%. The DUE on Phenobarbital was presented to the Pharmacy and Therapeutics Committee on 3/28/12. The recommendation was to continue to monitor individuals in a collaborative manner and further evaluate those individuals with less than 100% compliance. Based on review of DUE reports, discussions, and meeting observations, the monitoring team noted the following: • The DUE policy required that the Pharmacy and Therapeutics Committee determine the order of drug evaluations, sample size, develop a DUE schedule, develop, and approve a data collection form that specified the indicators and acceptable thresholds. The procedure also required that the committee interpret aggregate data and make recommendations for action and a plan of correction and provide this to QA. These decisions were made by the pharmacy director and not by the committee. The fact that the committee met quarterly may have impacted this function. • The objectives of the DUE were not clear and this likely contributed to a DUE that attempted to review too many aspects of drug use. Some of the criteria reviewed were not appropriate for the population being reviewed. • The data presentation and relevance of the data were not clear. The monitoring team discussed this during the various meetings. • The presentation of the DUE in the P&T committee was brief and lacked information that should have been shared with the committee. Throughout the various discussions, it was always emphasized that the DUEs were discussed with the physicians. The monitoring team reminded the medical director and pharmacy director that an objective of the DUE process was to educate health care professionals, and to promote the use of criteria, guidelines, treatment protocols, and standards of care.	

<table>
<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 continued to report medication variances. Pharmacy errors and physician prescribing (potential errors) were reported, though they were reported as one total number instead of separated into actual and potential mediation variances. Data for total variances, stratified by disciplines, are summarized in the table below.

<table>
<tr><td colspan="6">Medication Variances 2011 2012</td></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td></tr>
<tr><td>Nursing</td><td>101</td><td>58</td><td>70</td><td>84</td><td>89</td></tr>
<tr><td>Pharmacy</td><td>31</td><td>32</td><td>21</td><td>40</td><td>16</td></tr>
<tr><td>WORx</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td></tr>
<tr><td>Prescribing (Potential)</td><td>8</td><td>43</td><td>17</td><td>3</td><td>13</td></tr>
<tr><td>Total</td><td>140</td><td>133</td><td>108</td><td>128</td><td>118</td></tr>
</table>

The chairing of the Medication Error Committee was transferred from the medical director to the chief nurse executive. The committee did not meet during the last two to three months of 2011. Meeting minutes since the last visit were requested and the monitoring team was provided with minutes dated 1/20/12 and 2/3/12. According to the minutes, the reconciliation problems with mediations had been resolved. During the last onsite review, it was noted that 600 to 900 medications were returned monthly to the pharmacy with an average reconciliation rate of 35%.

The monitoring team attended the third meeting that was chaired by the CNE. During the meeting, it was reported that all medications were reconciled. There were no data reported to support this finding. The pharmacy did not present any medication reconciliation data at the Medication Error Committee meeting or the Pharmacy and Therapeutics Committee meeting. If there was 100% reconciliation, there was an obligation to report the data as such. In fact, there was no detailed data on medication errors presented at the MERC meeting and the monitoring team questioned the lack of this information. Appropriate analysis of a medication error requires specific information such as the medication involved, the number of doses, the type of error, and the number of days involved. The final determination cannot be made without that information. While the nursing department stated that it had reconciled every medication, it also became clear during this meeting that liquid medications were not reconciled.

There was no clear evidence that all issues related to the reconciliation of medications were resolved. Based on the data presented and the discussions that occurred during the MERC meeting, the committee had not met its obligation to collect data, analyze data, generate recommendations, and follow those recommendations through to completion.</td>
<td>Noncompliance</td>
</tr>
</table>

Recommendations:

1. Pharmacy director should counsel all pharmacists on the requirement to document communication and interactions with the prescribers (N1).

2. The pharmacy director should review the clinical intervention form and determine the need for a physician signature line. If there is no need for a physician review, the line should be removed (N1).

3. The pharmacy director and medical director should determine which clinical interventions should warrant follow-up and documentation to full resolution (N1).

4. The facility will need to work with State Office in outlining the requirements for fulfilling the need to complete laboratory monitoring as part of the prospective review (N1).

5. The management of drug-drug interactions must be clarified. The actions required for each level of drug interactions as well as the requirements for pharmacy staff and prescribers should be clearly defined in policy and procedure (N1).

6. The medical and pharmacy directors should closely monitor the compliance with the clozapine protocol and take corrective action as warranted (N1).

7. The medical director should review the CI/RPO data and analyze it. Patterns and trends related to physician practice patterns should be addressed. The data should also be reviewed to determine if systemic issues exist, such as appropriate documentation of allergies or availability of the correct formulations of medications for enteral tube use. The medical director should collaborate with the clinical pharmacist in developing educational opportunities for the medical staff based on the findings of the review (N1).

8. The Drug Regimen Reviews policy should be revised. It should clearly specify how the clinical pharmacist will complete the reviews and the time frames for doing so. It should outline the responsibility for publishing the QDRR schedule, which should be completed in accordance with state guidelines. The policy should also include the new electronic process implemented in January (N2).

9. The clinical pharmacist should comment on every medication for which there is a monitoring parameter included in the Lab Matrix. The actual values should be provided. Documentation by exception should not occur (N2).

10. The clinical pharmacists should ensure that all individuals who are on antiepileptic drugs associated with a greater risk of osteoporosis have appropriate evaluations including measurement of vitamin D and bone density testing. This is particularly important since the neurology clinic notes currently do not address these issues (N2).

11. The QDRR Response Form should be considered for revision:
    a. A provider should be able to readily determine that he or she must address a recommendation.
    b. There should be an option to indicate that the recommendation is not applicable (N2)

12. The clinical pharmacist should track the responses of the physicians to the QDRR recommendations. The medical director should review this information and counsel the medical staff as indicated (N4).

13. The facility must ensure that employees have adequate training on completion of the MOSES and DISCUS evaluations. Documentation of training and attendance should be maintained (N5).

14. The results of the MOSES and DISCUS evaluations should be provided to the neurology consultants. The primary care physicians should also review the data and consider documenting scores and findings in annual and quarterly assessments (N5).

15. The facility must take several actions in advancing the ADR system:
    a. The procedure, consistent with state issued policy, should be revised to guide the process. The procedure should include the responsibilities of the various disciplines, how reporting occurs and who completes the form.
    b. The requirements for use of the probability scale and intense case analysis should also be included.
    c. Data reporting, tracking and analysis requirements should be outlined.
    d. The role of the Pharmacy and Therapeutics Committee should be included.
    e. Training requirements should be documented: All health care professionals (medical providers, pharmacists, nurses, and respiratory therapists) and direct care professionals must receive training on detecting and reporting adverse drug reactions. The training should be appropriate for each discipline (N6).

16. The Pharmacy and Therapeutics Committee should record minutes for each meeting. The document should include the discussions of the meeting with data presented, actions steps that need to occur and the persons responsible for those steps. Timelines for completion of the action steps should also be included. Open items should be reviewed at the follow-up meeting. Consideration should be given to conducting the meeting bi-monthly (N6).

17. The Pharmacy and Therapeutics Committee should provide a synopsis of the ADR data including the final determination, follow-up, and action steps that need to occur (N6).

18. The focus of the DUEs should be narrowed. A DUE should be limited to a review of 3-5 criteria. Additional DUEs should be scheduled if the results warrant it (N7).

19. A corrective action plan should be developed for any deficiencies noted during the conduct of completing DUEs. The actions should be specific, have timelines, and identify the person(s) responsible for the actions. This should be reflected in the Pharmacy and Therapeutics Committee meeting minutes (N7).

20. The facility must ensure proper oversight of the Medication Error Committee. The committee must provide clear data related to the reconciliation of medications. This process should be a combined effort of the medical, nursing and pharmacy departments (N8).

21. The MERC must provide an appropriate report to the Pharmacy and Therapeutics Committee of all medication variances. This should be a detailed report consisting of graphs, tables, and information that will provide members of the committee with enough information to perform adequate data analysis (N8).

22. The facility must determine how it will reconcile liquid medications (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o MSSLC client list o Admissions list o Budgeted, Filled, and Unfilled Positions list o PNMT Staff list and CVs o PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section)-Physical Nutritional Management o Settlement Agreement Section O: PNMT Audit forms submitted o Performance Evaluation Team Monthly Provision Action Information Worksheet Section O o Client Management policy and procedure draft (11/3/11) o Physical Nutritional Management Plan Monitor Procedure draft (11/21/11) o Physical Nutritional Management Plan Monitor the Monitor Procedure draft (11/21/11) o PNM spreadsheets submitted o PNMT Assessment template o PNMT meeting minutes o Individuals with PNM Needs o PNM Monitoring tool templates o Completed PNMP Monitoring Forms submitted o Monitor the Monitor forms submitted o PNMP monitoring schedules and assignments o NEO curriculum materials related to PNM o List of PNMP monitoring completed in the last quarter o List of hospitalizations/ER visits/Infirmary Admissions o Tracking of Modifications of Wheelchairs o Individuals at Risk for Choking, Falls, Skin Integrity, Aspiration, Fecal Impaction (bowel obstruction/constipation), and Osteoporosis o Modified Diets/Thickened Liquids o Individuals with Texture downgrades o Chronic Respiratory Infections o Individuals with Fecal Impaction o Individuals with MBSS in the last year o Poor Oral Hygiene o Pneumonias in the Past Year o Aspiration Pneumonia

	o Individuals with Choking Incidents and related documentation: • Individual #446, Individual #424, Individual #524, and Individual #525 o Individuals with BMI Less Than 20 o BMI Greater Than 30 o Individuals with Greater Than 10% Weight Loss o Falls o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals with Skin Breakdown in the last 12 months o Fractures o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Wheelchair seating assessments/documentation submitted o Individuals Who Use Ambulation Assistive Devices o Orthotic Devices o List of competency-based training in the last six months o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPS submitted o Observation Notes (3/29/12: Individual #151, Individual #369, Individual #304, Individual #511) o PNMT Assessments and ISPs: Individual #542 and Individual #391 o PNMT draft assessments: • Individual #72, Individual #38, Individual #151, and Individual #533 o PNMT Action Plan: Individual #435 o APEN Evaluations: • Individual #306, Individual #395, Individual #61, Individual #302, Individual #72, Individual #293, Individual #578, Individual #512, Individual #35, and Individual #220 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, 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 #432, Individual #477, Individual #533, Individual #120, Individual #229, Individual #222, Individual #435, Individual #542, Individual #84, Individual #61, Individual #369, Individual #341, Individual #524, Individual #304, Individual #562, Individual #272, Individual #427, Individual #446, Individual #151, Individual #188, Individual #518, Individual #266, and Individual #229. o PNMP section in Individual Notebooks for the following: • Individual #432, Individual #477, Individual #533, Individual #120, Individual #229,

	Individual #222, Individual #435, Individual #542, Individual #84, Individual #61, Individual #369, Individual #341, Individual #524, Individual #304, Individual #562, Individual #272, Individual #427, Individual #446, Individual #151, Individual #188, Individual #518, Individual #266, and Individual #229. o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #432, Individual #477, Individual #533, Individual #120, Individual #229, Individual #222, Individual #435, Individual #542, Individual #84, Individual #61, Individual #369, Individual #341, Individual #524, Individual #304, Individual #562, Individual #272, Individual #427, Individual #446, Individual #151, Individual #188, Individual #518, Individual #266, and Individual #229. <u>Interviews and Meetings Held</u>: o Brandie Howell, OTR, Habilitation Therapies Director o Sandra Opersteny, PT o Christopher Ross, OTR o Fran Harman, MS, CCC/SLP o Loretta Gallegos, RN o Jennifer Capers, RD, LD o Christopher Ellis, MD o Pamela Harlan, COTA o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas, dining rooms, day programs o PNMT meeting
	Facility Self-Assessment: MSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. The Presentation Book for O provided information related to actions taken, accomplishments, and work products. The facility was to describe, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, and documentation of the results of the self-assessment. The activities listed did not actually represent actions that assessed the status of compliance with the provision items, but rather merely listed documents reviewed or general activities. The results reported were limited to numbers and percentages of items completed, but there was no clarity as to how those listed provided

	assessment of compliance. In all cases, there was no statement of what the "universe" was and in many cases the data conflicted. The Habilitation Therapies Director had read the previous monitoring report and attempted to respond to the recommendations and suggestions. This was a great step in planning for self-assessment and the development of action plan. In most cases, however, data were merely reported, but not in a context of assessment or to provide analysis. In some cases, the data were reported in a manner different from that in the monitoring report. Another aspect that was the challenge in understanding the somewhat subtle difference between assessing whether substantial compliance was met versus engaging in activities to meet substantial compliance. The statewide self-monitoring tool may be one of the activities used to self-assess, but will not likely be sufficient for most provision items and the action plans may not always address everything that needs to be addressed. The monitoring team conducted a lengthy discussion with the department director regarding approaches to the self-assessment process and it is hoped that this provided a clear direction for the future. The facility self-rated itself as in substantial compliance with O2 and O7 and in noncompliance with the other provision items. Actions taken were definite steps in the direction of substantial compliance, but the monitoring team did not concur at this time based on the findings reported below.
	Summary of Monitor's Assessment: There was a fully-constituted PNMT, including a full time nurse and OT. While a dietitian and physician were listed as core team members and they contributed in the assessment process to some degree, there was no evidence that these two members had attended any meetings. The Chairperson, OT, SLP, and PT had met consistently, at least weekly. There was a lack of nursing representation between December 2011 and 3/1/12, when the new PNMT nurse was hired. A meeting observed during this review showed some improvement in their process since the last review. All team members participated in discussion that reflected active assessment and supports. It was of significant concern, however, that the team was taking three to four months to complete an assessment and only two had been completed in the last six months. The assessment was voluminous and consisted predominately of extensive medical history information. These appeared to be more of an extensive record review rather than an actual assessment of the individuals' current status and issues. It was difficult to discern actions taken, completed, and assessed for their effectiveness. The IDT did not participate in any of the PNMT meetings, though some team members did attend ISPAs to review hospitalizations, other changes in status and to present assessment findings. These concerns were discussed extensively with the PNMT members. Continued experience with the PNMT process will likely result in further refinement. At this time, the PNMT waited on referrals to initiate assessment or other review. This was not necessary - key clinical indicators and health risk status should drive identification of the need for PNMT supports and services. The PNMT may want to consider initiating

	review of all individuals with aspiration pneumonia, and other key clinical indicators including bacterial/non-classified pneumonia, repeated hospitalizations, choking incidents, or significant or consistent weight loss, for example. Mealtimes were observed in a number of homes. Overall, there appeared to be improvements related to implementation of the dining plans, particularly in Barnett and Martin 4 dining areas. Positioning continued to be an issue, though, in general, the wheelchairs looked better. Staff continued to need training related to understanding effective alignment and support as well as the elements of transfers. Staff did not understand the relationship of individual risks and triggers to their duties and responsibilities. Some staff were better able to answer questions about implementation of the plans and this was an improvement over previous reviews. Staff documentation was a significant concern and as described below, some staff had completed essential notes well before their shift was completed, thus apparently falsifying some key information. While this may have been isolated to a particular home, it would be well worth examining facility-wide to correct this swiftly and thoroughly. Monitoring frequency was nearing excessive and, as such, could not possibly be properly reviewed and analyzed.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary,	<u>Core PNMT Membership</u>: The current core team members of the PNMT included: Brandie Howell, OTR, Chairperson; Sandra Opersteny, PT; Christopher Ross, OTR; Fran Harman, MS, CCC/SLP; Loretta Gallegos, RN; and Jennifer Capers, RD, LD. Christopher Ellis, MD served routinely as the physician on the team. Each of these team members was a full-time state or contract employee. Only the nurse and OTR served full-time on the PNMT. Each of the others had additional responsibilities as IDT therapists or in leadership roles. <u>Continuing Education</u> Continuing education was documented for the core members of the team with the exception of the RN, as she had recently replaced the previous nurse on the team. Each team member had attended core PNMT training in August 2011. Additional continuing education was documented related to assessment of individuals with developmental disabilities, dysphagia management, and/or seating for each team member. This level of continuing education was adequate. It is critical that this team continue to achieve and maintain the highest possible level of knowledge and expertise in the area of PNM. Consideration of PNM-related continuing education opportunities for all team members in addition to the state-sponsored conferences/webinars should be a priority.	Noncompliance

#	Provision	Assessment of Status	Compliance
	approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, 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.	<u>Qualifications of Core Team Members</u> Resumes/CVs were submitted for each of the team members listed. Each of the team members had documented more than three years of experience in their respective fields. <u>PNMT Meeting Frequency and Membership Attendance</u> Spread sheets were submitted that were titled MSSLC Physical Nutritional Management Meeting Minutes and reflected documentation of 20 weekly minutes between 10/7/11 and 2/17/12. There were no sign-in sheets, but 19 of the 20 spreadsheets (i.e., not 10/7/11 listed the attendees. Attendance was limited to core team members only. Information in the meeting minutes was very general, such as "follow along," "assessment in process," or "update on orthopedic clinic." This documentation reflected little about the actions taken by the PNMT. Attendance by core team members from 10/14/11 to 2/17/12 (19 meetings) and 3/9/12 to 3/30/12 (four meetings) was: • Chairperson: 96% • RN: 70% • PT: 96% • OT: 96% • SLP: 96% • RD: 0% • MD: 0% One spreadsheet did not indicate that any team member had attended. Though there was no evidence that the MD or RD had attended any meetings during this period, they were both present at the meeting observed by the monitoring team during this onsite review. During this meeting, the participation of both was exceptional and they were knowledgeable and competent. Ms. Capers was the only dietitian serving the entire facility. She could not possibly adequately meet the needs of 390 individuals let alone participate adequately as a core team PNMT member. By report, the PNMT called her when needed. It appeared that the physician reviewed each of the completed PNMT assessments and that all core team members signed the reports. Consistent attendance by the other core team members was generally adequate, with the exceptions of representation by the RN. The previous RN had resigned in December 2011 and the replacement nurse had been hired as of 3/1/12. She reportedly had attended weekly meetings since that time. It is critical that all core team members participate in each meeting of the PNMT as this is key to the provision of appropriate and adequate services. <u>Ancillary PNMT Members</u> No ancillary team members participated on the PNMT and no IDT members attended any PNMT meetings. On occasion, the PNMT or selected team members attended specific IDT meetings for individuals who were reviewed, or were being considered for review, by the	

#	Provision	Assessment of Status	Compliance
		PNMT. It was of concern that key clinicians, such as a physician, dietitian, nurse, or psychologist did not participate in critical discussions of the health status of these high risk individuals during the PNMT meetings**.** Other key staff should include, at a minimum, the QDDP, nurse case manager, and psychology, or any other IDT members who know the individual well and could participate in the development of an effective approach to mitigating risks and conditions that resulted in PNMT referral. Attendance by core team members and participation by key IDT members was not consistent.	
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.	<u>PNMT Referral Process</u> Since 10/14/11 (the meeting minutes for 10/7 /11 were incomplete), the PNMT had reviewed 10 individuals: Individual #435, Individual #542, Individual #477, Individual #391, Individual #369, Individual #72, Individual #38, Individual #151, Individual #222, and Individual #188. Only two of these had received a PNMT assessment (Individual #391 and Individual ##542). • Individual #391: Her assessment reported that a referral to the team was made and received on 11/7/11 for aspiration pneumonia. The PNMT assessment was in process through 1/13/12, and revisions to the draft report continued through 2/3/12. The assessment was submitted the draft to the PNMT physician for review on 2/10/12 and an ISPA was held on 2/16/12 to present assessment results and recommendations to the IDT. This final key step took place over three months after the initial referral. • Individual #542: Her assessment indicated that a referral to the PNMT was made on 9/15/11 and received on 9/19/11, also for aspiration pneumonia. There was no evidence that the PNMT had tracked her status and recognized a need for an assessment at any time over the course of 11 hospitalizations prior to the referral. The meeting minutes indicated that the final draft had been completed on 12/21/11 with revisions made on 12/16/11 and 12/23/11. An ISPA to discuss the findings and recommendations was pending for several weeks and finally conducted on 1/20/12. The actual document was stamped as received for placement in her individual record on 1/25/12, over four months after the initial referral. Based on this, the monitoring team requested additional assessments completed by the team since January 2012 to the time of the onsite review. Drafts for Individual #72, Individual #533, and Individual #38 were submitted. • Individual #72: His report was dated 3/13/12 though the team had received a	Noncompliance

#	Provision	Assessment of Status	Compliance
		referral on 11/21/11. The assessment was documented as in process since that time, per the meeting minutes. • Individual #533: His draft PNMT assessment was dated 2/23/12 with a referral date listed as 2/7/12 related to respiratory compromise, choking, and aspiration. The assessment was listed as in process since that time. • Individual #38: His draft assessment was not dated, though the meeting minutes indicated the PNMT SLP and OT attended a post-hospitalization ISPA meeting on 1/27/12 during which it was determined that referral to the PNMT would be made if his status had not improved in one week. He was hospitalized a week later and a referral made to the PNMT on 2/7/12. His assessment was reported to be in process since that time. Anyone should be able initiate a referral to the PNMT, including the PNMT members themselves. Therefore, it was not necessary, and certainly was not acceptable, to necessarily wait for a referral from the IDT in cases where PNMT assessment was indicated. Similarly, however, a referral to the PNMT also indicates that there is an urgent need for specialized supports and services and, as such, the assessment process should be completed in a timely manner. There assessments should be completed in a month or less and actions to address identified needs should be implemented throughout the assessment process. <u>PNMT Assessment and Review</u> Assessments were initiated only upon referral. As stated above, only two individuals had been provided completed PNMT assessments and three others were in process at the time of this review. Again, the assessments were not completed in a timely manner. Further, there was little evidence to suggest that the PNMT was active on the case during that time. For example, in the case of Individual #542, there were only two entries in the IPNs by the PNMT, one stating that they had initiated her assessment on 10/4/11 and on 10/5 to complete a head of bed evaluation (HOBE). Other progress note entries (six) by the IDT therapists were related to staff training, the annual assessment, bathing assessment, orthotic clinic, and orthopedic shoes. On 1/20/12, her risk rating tool was updated and recommendations were reviewed. There was no evidence that many of these had been implemented during the four month assessment period or following the ISPA meeting on 1/20/12. It was of grave concern that the PNMT took over four months to complete an assessment and that few changes resulted in her plan of care. The two completed PNMT assessments were consistent in format with like headings. There was extensive historical documentation with more limited current physical status assessment. Many of the recommendations should have been implemented during the	

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		extended assessment period, but were not. There were a wide variety of domains addressed in the assessment reports, but there was a lack of new clinical findings and, essentially, no analysis of the plethora of information obtained from record reviews. The majority of the information reported was not utilized for the analysis and did not appear to impact decision making with regard to recommendations. There was no documented follow-up by the PNMT post-hospitalization. <u>Risk Assessment</u> Health risks were reported in the two PNMT assessments, with a comparison to that established by the IDT, and recommendations for revisions based on clinical or historical findings. In the case of the risk rating tools reviewed, an original tool was completed and the plan was dated at that time. The plan was reviewed generally on a quarterly basis, post hospitalization, or if there was any change in status. It was not clear, however, whether changes in the ratings were made, but rather only the review date was added. In the case that an action plan item was added, the date of implementation was used. Risk assessment ratings for the individuals selected in the sample by the monitoring team were requested. There were a number of inconsistencies in the risk ratings for a number of individuals. Though improved since the previous review, the rationales continued to be weak and ratings were often inconsistent with clinical indicators. Some examples included: • Individual #427 was described with dysphagia, required a pureed diet and honey thick liquids yet he was considered to be only at LOW risk for choking. He was considered to be at HIGH risk for constipation/bowel obstruction, yet he was considered to be at LOW risk for gastrointestinal problems and GERD. He was considered to be at HIGH risk for osteoporosis and medium risk of falls, yet was considered to be only at medium risk for fractures. His skin integrity risk was considered low, yet he was seated in a wheelchair full time due to his non-ambulatory status and was incontinent. • Individual #272 was identified at LOW risk for cardiac disease. The rationale was merely that she had no cardiac diagnosis and her BMI was 24.3. In a related area, however, she had reported edema in lower extremities, requiring high compression socks, daily rest periods, and leg elevation in her wheelchair. She was considered to be only at MEDIUM risk. • Individual #562 was identified with insufficient chewing skills, missing teeth, and was on a chopped diet. He was listed only at LOW risk of choking. He had a fall on 12/29/11 that resulted in multiple facial fractures, yet was considered to be at LOW risk of falls. He received two medications for psychosis and intermittent explosive disorder and a third to address tardive dyskinesia, yet was considered to be at low risk for polypharmacy and side effects.	

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		As stated above, the action plans associated with the risk rating tools generally listed routine care and protocols for the risk concerns identified rather than unique and/or appropriately more aggressive interventions to address the identified risks. For example, the plans would list such things as "medication," "monitor," or "positioning" and were not individualized.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>PNMP Format and Content</u> There were approximately 274 individuals or 70% of the current census, identified with PNM needs and provided with PNMPs (approximately 272 were submitted). Comments related to the 22 PNMPs reviewed are provided below. Improvements in the format and content are indicated. Improvement was observed in the implementation of the plans. • PNMPs were submitted for 22 of 22 (100%) individuals included in the sample. • None of the 22 PNMPs (0%) of these included photographs for positioning or adaptive equipment. • PNMPs for 22 of 22 individuals in the sample (100%) were current within the last 12 months. • PNMPs for 19 of 21 individuals in the sample (86%) were of the same format. • In 22 of 22 PNMPs reviewed (100%), positioning was addressed. • In 19 of 19 PNMPs reviewed (100%) for individuals who used a wheelchair as their primary mobility or for transport, some positioning instructions for the wheelchair were included, though generally minimal. No pictures of how the individual was to be aligned and supported in the wheelchair were available. • In 22 of 22 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 22 of 22 PNMPs reviewed (100%), the PNMP had a distinct heading for bathing instructions. • In 14 of 22 (64%) of the PNMPs reviewed, toileting instructions were provided. • In 20 of 22 (91%) of the PNMPs reviewed for individuals who were not described as independent with mobility or repositioning, handling precautions. These instructions varied greatly in detail and, in most cases merely directed staff to handle the individual with care due to fragile bones, but specific handling techniques were not outlined. • In 22 of 22 PNMPs reviewed (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • There were 10 of 22 individuals (45%) who had feeding tubes. Two of these PNMPs (Individual #533 and Individual #369) did not indicate whether the individuals were NPO (nothing by mouth). One (Individual #61) also received oral intake and mealtime instructions were provided.	Noncompliance

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		• In 17 of 22 PNMPs reviewed (77%), dining position for meals or enteral nutrition was provided, though two of these only indicated that the individual was to remain upright following the meal, but not the position during the meal. • In 12 of 13 PNMPs reviewed (92%) for individuals who ate orally, diet orders for food texture were included. • In 12 of 13 PNMPs for individuals who received liquids orally (92%), the liquid consistency was clearly identified. • In 10 of the 13 PNMPs for individuals who ate orally (100%), dining equipment was specified in the dining equipment section. The others did not state that regular utensils were used, so it was not clear if equipment was omitted or not indicated. • In 22 of 22 PNMPs reviewed (100%), a heading for medication administration was included in the plan. These instructions generally referred to the form of the medication (whole pills or crushed), whether to mix with applesauce or pudding, and whether an adaptive cup was to be used. • Other adaptive equipment was not listed for any of the individuals and positioning was addressed for only nine of the 22 plans reviewed (41%). • In 22 of 22 PNMPs reviewed (100%), a heading for oral hygiene was included in the plan. In some cases (17), instructions and positioning were included in this section, beyond a general statement to assist with toothbrushing after each meal. • 22 of 22 PNMPs (100%) reviewed included a heading related to communication. Specifics regarding expressive communication or strategies that staff could use to be an effective communication partner were absent in all the PNMPs. Four plans stated merely that the individual was verbal. Two referred to devices and the Communication Dictionary. Six plans identified how the individual communicated and referred staff to the Communication Dictionary to interpret these behaviors. In many cases, staff were merely referred to the Communication Plan for interpretation of communicative behaviors, though three incorrectly identified the dictionary itself as a mode of communication (Individual #61, Individual #446, and Individual #188). There were a number of PNMPs submitted for individuals who were identified as independent in all areas and were verbal communicators. They ate regular diets and did not require modified liquid consistencies. These individuals were provided PNMPs merely because they wore eyeglasses. This unnecessarily required routine monitoring of the plan and an annual assessment by the therapists. This was an inappropriate and unnecessary application of the concept of the Physical Nutritional Management Plan (e.g., Individual #177 and Individual #88). Others only required lotion to be applied to their feet after bathing (Individual #10, Individual #253, and Individual #329). Individual #153 had bilateral insoles in his shoes and Individual #199 wore dentures and eyeglasses.	

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		There were other systems to adequately address these supports, such as the nursing care plan and the ISP. Additionally, it had been decided that all individuals living at MSSLC must have a Dining Plan. Thus, there were over 100 individuals with Dining Plans who did not require a PNMP. These plans necessitated an annual assessment by the therapists. Again this appeared to be an unnecessary activity. Three of the ISPs in the sample were not current within the last 12 months (Individual #562, Individual #229, and Individual #427). There was no sign in sheet submitted with the ISP for Individual #341. ISP meeting attendance by team members was as follows for the current ISPs included in the sample for whom signature sheets were present in the individual record (also see section F above): • Medical: 3 of 18 (17%) • Psychiatry: 0 of 18 (0%) • Nursing: 18 of 18(100%) • RD: 14 of 18 (78%) • Physical Therapy: 14 of 18 (78%) • Communication: 13 of 18 (72%) • Occupational Therapy: 15 of 18 (83%) • PNMPC: 2 of 18 (11%) • Psychology: 12 of 18 (67%) It would not be possible to achieve adequate integration given these levels of PNM-related professional participation in the IDT meetings. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective action plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. PNMPs could not be reviewed and revised in a comprehensive manner. The Physical Nutritional Management Plan was referenced in the majority of the ISPs reviewed, though review of the PNMP by the IDT was not evident in any of those (0%). There was no consistency as to the manner or content of how the PNMP was addressed in the ISPs. In some cases, strategies were included. In others, it was mentioned only that the individual had a PNMP. It would be extremely difficult for staff to locate information needed to further understand the PNMP. The PNMP was not well integrated into the individual's ISP as a result. Activity Plans had been developed for the purpose of quarterly monitoring of equipment included in the PNMP. It was not clear why the entire PNMP was not reviewed quarterly, but rather specific pieces of equipment only. There was no evidence of consistent review by the IDT in relation to identified risk and the efficacy of the interventions implemented. In some cases, statements from the	

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		assessments were included in the ISP, but there was no element that indicated the information was discussed or that the PNMP was reviewed by the full IDT. The QDDPs may require greater guidance as to consistent strategies to incorporate PNMP information into the ISPs and action steps.	
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.	<u>PNMP Implementation</u> PNMPs and Dining Plans were developed by the therapy clinicians with limited input by other IDT members. Continued efforts to increase attendance at the ISPs and ISPAs, and continued participation of other team members in this process, should ensure that there is improved IDT involvement in the development of the plans. Dining Plans were available in the dining areas. 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. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright. 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 and in individual-specific training provided by the therapists and PNMPCs. <u>Observations</u> There was clear improvement in some homes, and less so in others. Some examples are presented below in hopes that this detail will be useful to the facility: • Individual #61: Her plan indicated that her wheelchair should be tilted to 35 degrees or to the green marking tape. The tape marked the wheelchair at 25 degrees. • Individual #477: Staff assisting her followed her plan with regard to filling her glass one quarter full, though did not know why this was important. • Individual #377: Her plan stated she should use a wheelchair outside of the home. She was observed propelling herself in a wheelchair inside her home. The wheelchair was extremely dirty. • Individual #140: He was observed leaning to the left and was poorly aligned and supported. While the staff reported that they were trained on the ISP, they were not able to identify his risks for falls and fractures. • Individual #427: Staff were not alternating food and fluid as instructed on his Dining Plan. The staff also did not apply downward pressure for presentation. He was offered large amounts of liquefied pureed food with significant loss. Staff did not provide effective jaw support. He coughed three times and staff told him to stop rather than adjust the assistance techniques or report it to nursing. o He did, however, look better aligned and supported in his wheelchair	Noncompliance

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		than he had during previous observations by the monitoring team. • Individual #533: He was sitting on his left hip with his shoulders twisted to the left during a tube feeding. A helmet hung for the back of his chair though it was on his PNMP to wear it throughout the day. • Three were no individual books available for Individual #511, Individual #304, or Individual #369. Staff had to go look for them when requested by the monitoring team. • Staff had difficulty performing mechanical lift transfers to the bed from the wheelchair and back for Individual #304 and Individual #511. They did not properly adjust the sling and did not guide their hips into the wheelchair. They did not speak to Individual #304 during the process. • Individual #304: Toothbrushing observed. Masks were not available for staff use in the bathroom area. There was no soap dispenser in the bathroom. There was only one pair of protective eye wear for use by all staff with all individuals. • On 3/29/12, in Martin, it was noted that for at least four individuals (Individual #151, Individual #304, Individual #511 and Individual #369), direct support staff had completed the documentation on these individuals prior to their shift being completed. In the case of Individual #369, one staff had fabricated data. The monitoring team was in the home before noon, yet documentation for 1:15 related to check and change and positioning was already completed at that time. Other documentation related to the PNMP and equipment, injuries, seizures, medical issues reported to nursing, and others were already documented as NA at noon though the staff worked the six to two shift. The majority of staff were not able to verbalize the rationale for the strategies included in the plan, though several who did answer the questions did so confidently and accurately. <u>Choking/Aspiration Events</u> Ten individuals were listed with choking events in the last year and three of these had two choking incidents (Individual #525, Individual #431, and Individual #215). All of these were on food items, though only five were reported to require abdominal thrust. There was no evidence of review by the PNMT in any of the cases that occurred in the last six months (Individual #524, Individual #424, Individual #446, and Individual #525). It would be expected that the PNMT would review <u>any</u> choking event, particularly for Individual #525 since it was his second in less than 12 months. • Individual #446 choked on pineapple on 10/28/11. The nurse documented that the pineapple on the tray was too big. Individual #446 was on a ground diet. The Dining Plan was not revised until three days later and the adaptive equipment was not changed until 11/8/11, over 10 days later. If a thorough multi-disciplinary assessment had been conducted at the time of this incident, the	

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		necessary changes to her Dining Plan would have been identified and implemented in a more timely and coordinated manner. There was no evidence of follow-up to determine if the changes made were effective. Her record stated that she did not have dysphagia, yet she was prescribed a ground diet. She had not received a modified barium swallow study (MBSS). • Individual #524 choked on a piece of pizza on 9/30/11. Though she was prescribed a chopped diet (sugar cube size), direct support staff indicated that the pieces were cut in one and half inch pieces from the kitchen and that they had cut them into smaller pieces, but the individual had eaten too fast. Her "airway became blocked" and the LVN leaned her forward, provided one back thrust and the food was expelled. A subsequent ISPA documented that the SLP had conducted an assessment and recommended that her diet be downgraded to ground and an MBSS. It was of considerable concern that the IDT did not meet immediately, but rather three days after the incident and changes to her plan and staff training did not occur for at least four days. There was no evidence that an MBSS had been completed. Individual #524 was monitored on 12/8/11, 2/22/12, 2/23/12, and 2/24/12, though it could not be determined if these related to mealtime. • Individual #525 had choking incidents on 3/2/11 (chicken nuggets) and again on 11/9/11 on a roll. Neither incident was reported to have required abdominal thrust. He was monitored on 12/14/11 and 2/16/12 only. It could not be determined if this had been related to mealtime. He was diagnosed with aspiration pneumonia on 3/2/11. • Individual #424 choked on chicken nuggets on 10/12/11. A consult by the SLP was documented the next day on 10/13/11. Changes to his Dining Plan were recommended and an ISPA was to be requested with SLP follow-up two times per week as required. Individual #424 had been monitored frequently on 11/1/11, 11/9/11, 11/17/11, 11/23/11, 12/13/11, 12/20/11, 1/3/12, 1/6/12, 1/11/12, 2/6/12, 2/9/12, 2/16/12, 2/18/12, and 2/28/12, though it could not be determined if any of these pertained to mealtime. The number of choking incidents was excessive and was of concern to the monitoring team. More attention must be directed to this issue with greater involvement by the PNMT to prevent choking incidents and respond in a timely manner when they do occur.	
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	<u>New Employee Orientation</u> The NEO training included three hours dedicated to lifting, transfers, and positioning. Only transfers included a competency check-off. Dining plans and mealtime issues were covered in one hour and fifteen minutes with only a written test. Food textures, liquid consistencies, and dysphagia were covered in a four hour session that also addressed	Noncompliance

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	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.	communication and AAC. PNMPs were addressed in a one hour and 10 minute session. This time had been reduced since the previous onsite review. There was only annual retraining in lifting and transfers in a one hour course. These times were extremely inadequate to ensure staff competency in these key PNM-related areas. The lack of skills-based competency check-offs was also of significant concern to the monitoring team and this was reflected in the observations noted above. A 90-day mentoring process had been conducted during the last quarter. A representative that included OT, PT, SLP, and therapy assistants were present at every meal. They completed a report for each meal, there was a plan to meet with the residential staff, and they were to write a corrective action plan to address the findings. This did not appear to involve actual training, but rather another system of monitoring. <u>Individual-Specific PNMP Training</u> Inservice training for changes in the Dining Plans and PNMPs were conducted by both therapists and PNMPCs. A general inservice was completed with check-offs conducted with specific staff. The training sheet described the training content and, in some cases, the plan was attached. There was no evidence that this training was competency-based with return demonstration, but rather each indicated that there was a verbal quiz only. There were no written procedural guidelines to describe this process to ensure consistency. In the case that a PNMPC conducted the training, there was no evidence that they had been competency-trained with return demonstration to implement all aspects of the plan or be able to conduct training to establish competency with direct support staff. <u>Trainer Competencies</u> When new equipment was issued, the licensed clinician conducted the initial inservice training on the home and all PNMPCs were to attend. By report, this was competency-based, though the sign-in sheets suggested that training was not skills-based, but rather competency was established via a verbal quiz only. At that time, the PNMPC assigned to the home was to conduct any further staff training. There was no evidence of a training module for PNMPCs. It was reported to still be in process at the time of this onsite review. Training was not consistently effective, as evidenced by the implementation errors observed by the monitoring team and described above. Further support and training of the PNMPCs was indicated.	
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	<u>Monitoring Staff Competency and Compliance</u> Monitoring of staff competency and compliance was documented on a PNMP Monitoring form. Frequency of this monitoring, conducted largely by the PNMPCs, was reported to be based on risk levels as established by the IDT. The Action Plans, however, were not well developed and did not generally address the frequency of monitoring required. Individuals at high risk in an area were monitored twice weekly and others were to be	Noncompliance

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	that the staff demonstrates competence in safely and appropriately implementing such plans.	monitored on a weekly basis by the PNMPCs. Others, with more limited PNM-related supports, were to be monitored on a monthly basis only. Therapy staff were to complete a monitoring form on one individual per week, but this was reported to not be occurring consistently and there was no system to track frequency or the individuals monitored. The selection of the individual was not based on risk level. There was an exorbitant number of monitoring forms completed, though there was no system to review, analyze, and utilize the findings to direct system change, staff training and other supports. It was reported that due to staffing limitations, the frequency of monitoring of the high risk individuals was reduced rather than the monthly monitoring for individuals who merely had eyeglasses, shoe insoles, dentures, or ear plugs for bathing. The activities monitored were random and there was no system to ensure that all areas of the PNMP were monitored on a routine and consistent basis. The majority of the PNMP monitoring sheets submitted reported 100% compliance with implementation of the PNMP. This was surprising given the observations noted by the monitoring team (listed above) and should have been previously identified by a PNMPC.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>Individual-Specific Monitoring</u> As described above, the current monitoring system for implementation compliance and staff competency was based on individual risk levels, but there was no system to ensure consistency. PNMPs were revised as needed throughout the ISP year. Review of the plans occurred during annual assessments. Changes were generally documented via an ISPA. The ISP process was again undergoing changes and it is hoped that this will be addressed via implementation of those modifications. The monitoring team looks forward to seeing improvements with this over the next six months. <u>Effectiveness Monitoring</u> As described above, effectiveness monitoring of the PNMPs was limited to annual assessment, with changes in status, or by request. In addition, Activity Plans were developed for the sole purpose of quarterly review by the therapy clinician. It was not clear why it was not merely a policy to review the entire PNMP on a quarterly basis or more often for individuals at higher risk without the extra paperwork and duplicative documentation (i.e., Activity Plan and the IPNs). There did not appear to be an elevated level of review of effectiveness of plans for individuals with increased risk other than routine quarterly review. In most cases, the effectiveness of interventions and supports were not specifically addressed in the annual assessments. This should be a key function of the professional staff clinicians.	Noncompliance

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		Validation of Monitoring by PNMPCs A draft policy was developed to address validation of competency of the PNMPCs as monitors and trainers. This had not yet been finalized and full implemented. A small number of these had been completed, for only five PNMPCs in 2012.	
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.	Individuals Who Received Enteral Nutrition There were 32 individuals listed who received enteral nutrition. Individual #533, Individual #84, and Individual #61 were listed as having received new tube placement since the previous onsite review by the monitoring team. No one listed as recently placed on enteral nutrition was listed with a diet downgrade. None of these individuals had been assessed by the PNMT (with the exception of Individual #533 whose tube placement was on 10/26/11, but the assessment by the PNMT was not initiated until 2/7/12 and was still in process at the time of this review). Each individual with tube placement or who was at risk for tube placement should, at a minimum, be reviewed by the PNMT, if not provided a full comprehensive assessment. There were three individuals who received enteral nutrition who were also listed with poor oral hygiene (Individual #196, Individual #306, and Individual #474). The list submitted that identified individuals with aspiration pneumonia in the last 12 months included 19 incidences for 15 individuals since 2/3/11. Both Individual #72 (3) and Individual #188 (2) had multiple incidences of aspiration pneumonia. These individuals had not yet been evaluated by the PNMT, though an assessment for Individual #72 had been recently initiated. Another list identifying the occurrence of pneumonia in the past year included 45 incidences for 34 individuals. This list reported that there were 19 incidences of aspiration pneumonia for 15 individuals. There were 24 cases of bacterial pneumonia or non-classified occurrences that would not necessarily be ruled out as aspiration. Individual #542, Individual #72, Individual #391, Individual #432, Individual #273 and Individual #188 each had more than one instance of pneumonia in the last year. Only Individual #542 and Individual #391 had been evaluated by the PNMT and, as described above, these assessments took three to four months to complete. An assessment for Individual #72 had been initiated over one month ago. APEN Assessments A sample of APEN assessments was requested for 10 individuals for whom these were completed since the previous review. Two were completed for individuals who had occurrences of aspiration pneumonia and received enteral nutrition (Individual #72 and Individual #61). The other eight each had enteral nutrition, but were not listed with	Noncompliance

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		aspiration pneumonia in the last year. A measurable outcome was outlined for only 50% of the individuals for whom an APEN was submitted. There was limited discussion or analysis of the clinical findings. Further, it appeared to be prepared only by the RN rather than as a team process as intended. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP that included the same elements as described above.	

Recommendations:

1. Collaborate to design a better system to document the actions taken by the PNMT (O1).

2. Devise a system to access the existing data of risk, and occurrence of key clinical indicators and/or diagnoses to drive better identification of a need for PNMT review. This should effectively impact the referrals from the IDT as well as for self-referral (O2).

3. Ensure that the PNMT functions as an assessment team that includes 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. Use caution in the determination as to the need for assessment versus review only (O.2).

4. An action plan should be developed to drive the assessment and recommendations. A continuation of the plan should be integrated with the IDT in order to accurately and collaboratively complete the health risk assessment and action plan (O1 and O2).

5. Engage participation by the IDT in the PNMT assessment and action plan process (O1).

6. 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 and O7).

7. 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. This may particularly critical to needed improvements in positioning and transfers (O3-O6).

8. The IDTs continue to require support regarding risk assessment and real time modeling to effectively complete risk assessments and action plans. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks (O2).

9. Review the system of documentation required by direct support staff to address identified concerns (O5 and O6).

10. Reexamine the monitoring process to address frequency and assignment of PNMPCs (O6 and O7).

11. Implement a curriculum of content training for PNMPCs as soon as possible (O5, O6, and O7).

12. Review the dining plan content for appropriate detail of the focus statements and precautions in the plans. Content should primarily be related to instruction useful for effective staff implementation (O3 and O4).

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 Admissions list o Budgeted, Filled, and Unfilled Positions list o OT/PT Staff list o OT/PT Continuing Education documentation o Section P Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section P-Physical and Occupational Therapy o Settlement Agreement Section P: OT/PT Audit forms submitted o Performance Evaluation Team Monthly Provision Action Information Worksheet Section P o OT/PT spreadsheets submitted o Individuals receiving direct OT/PT o OT/PT Assessment template o OT/PT Services (SPOs, Programs, Activity Plans) o List of individuals receiving direct OT/PT services o Individuals with PNM Needs o List of hospitalizations/ER visits/Infirmary Admissions o Tracking of Modifications of Wheelchairs o Individuals at Risk for Choking, Falls, Skin Integrity, Aspiration, Fecal Impaction (bowel obstruction/constipation), and Osteoporosis o Poor Oral Hygiene o Pneumonias in the Past Year o Individuals with Choking Incidents and related documentation o Individuals with BMI Less Than 20 o BMI Greater Than 30 o Individuals with Greater Than 10% Weight Loss o Falls o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals with Skin Breakdown in the last 12 months o Fractures o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Wheelchair seating assessments/documentation submitted o Individuals Who Use Ambulation Assistive Devices o Orthotic Devices

	o List of competency-based training in the last six months o PNMPS submitted o OT/PT Assessments for individuals recently admitted to MSSLC: • Individual #124, Individual #393, Individual #174, Individual #90, and Individual #529. o OT/PT assessments, ISPs, ISPAs, SPOs and other related documentation for the following individuals receiving direct OT/PT services: • Individual #570, Individual #427, Individual #160, Individual #444, Individual #361, Individual #293, Individual #84, and Individual #449. o OT/PT assessments and ISPs for the following: • Individual #248, Individual #356, Individual #500, Individual #314, Individual #423, Individual #512, Individual #321, Individual #143, Individual #175, Individual #330, Individual #31, Individual #169, Individual #72, Individual #380, Individual #313, Individual #244, Individual #570, Individual #311, Individual #365, Individual #53, Individual #491, Individual #38, Individual #453, Individual #161, Individual #228, Individual #165, Individual #574, Individual #13, Individual #373, Individual #56, and Individual #401. o PNMPs submitted o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, 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 #432, Individual #477, Individual #533, Individual #120, Individual #229, Individual #222, Individual #435, Individual #542, Individual #84, Individual #61, Individual #369, Individual #341, Individual #524, Individual #304, Individual #562, Individual #272, Individual #427, Individual #446, Individual #151, Individual #188, Individual #518, Individual #266, and Individual #229. o PNMP section in Individual Notebooks for the following: • Individual #432, Individual #477, Individual #533, Individual #120, Individual #229, Individual #222, Individual #435, Individual #542, Individual #84, Individual #61, Individual #369, Individual #341, Individual #524, Individual #304, Individual #562, Individual #272, Individual #427, Individual #446, Individual #151, Individual #188, Individual #518, Individual #266, and Individual #229. o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #432, Individual #477, Individual #533, Individual #120, Individual #229, Individual #222, Individual #435, Individual #542, Individual #84, Individual #61, Individual #369, Individual #341, Individual #524, Individual #304, Individual #562, Individual #272, Individual #427, Individual #446, Individual #151, Individual #188,

	Individual #518, Individual #266, and Individual #229. Interviews and Meetings Held: o Brandie Howell, OTR, Habilitation Therapies Director o Wilfredo Diaz, PT o Sandra Opersteny, PT o Candy Quieng, PT o Jeffrey Ronquillo, PT o Gloria Miller, DPT o Betty Cotton, PTA o Linda Harwell, PTA o Teresa Wheeler, PTA o Sheila Michael, OTR o Doris Ricketts, OTR o Harvey Evans, DOT o Christopher Ross, OTR o Candice Drews, COTA, o Lisa Finley, COTA, o Karen Fleming, COTA o Pamela Harlan, COTA o PNMP Coordinators o Various supervisors and direct support staff Observations Conducted: o Living areas, dining rooms, day programs o OT/PT assessment
	Facility Self-Assessment: MSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. The Presentation Book for P provided information related to actions taken, accomplishments, and work products. The facility was to describe, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, and documentation of the results of the self-assessment. The activities listed did not actually represent actions that assessed the status of compliance with the provision items, but rather merely listed documents reviewed or general activities. The results reported were limited to numbers and percentages of items completed, but there was no clarity as to how those listed provided assessment of compliance. In all cases, there was no statement of what the "universe" was and in many cases the data

	conflicted. The Habilitation Therapies Director had read the previous monitoring report and attempted to respond to the recommendations and suggestions. This was a great step in planning for self-assessment and the development of action plan. In most cases, however, data were merely reported, but not in a context of assessment or to provide analysis. In some cases, the data were reported in a manner different from that in the monitoring report. Another aspect that was the challenge in understanding the somewhat subtle difference between assessing whether substantial compliance was met versus engaging in activities to meet substantial compliance. The statewide self-monitoring tool may be one of the activities used to self-assess, but will not likely be sufficient for most provision items and the action plans may not always address everything that needs to be addressed. The monitoring team conducted a lengthy discussion with the department director regarding approaches to the self-assessment process and it is hoped that this provided a clear direction for the future. The facility self-rated itself as in substantial compliance with P1 and in noncompliance with P2 through P4. Actions taken were definite steps in the direction of substantial compliance, but the monitoring team did not concur with the facility's self-rating of P1 based on the findings reported below. The monitoring team was in agreement with the facility's self-ratings for P2-P4.
	Summary of Monitor's Assessment: The level of staffing for OT and PT clinicians had remained relatively stable over the last six months despite most clinicians being on short term contracts. All of the staff had extended their contracts. The therapists appeared to be knowledgeable and enthusiastic. The OT and PT clinicians conducted their annual assessments. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment (e.g., wheelchairs), and to review other supports and services. Despite this, there was a continued concern for continuity. A great deal of on the job training had to occur for new staff and there needs to be a clear plan for orientation to ensure consistency of the information passed on to new therapists joining the facility. There was a sound assessment template, with guidelines for the comprehensive assessment, though none of the assessments reviewed were consistent with it and none included an appropriate analysis of findings or an adequate addressing of health risk levels in the context of the clinical findings. There continued to be a small number of individuals participating in direct PT and OT, though some also had programs and activity plans outlining additional supports and interventions. The majority of these were merely to ensure that the clinician conducted a quarterly review of equipment in the PNMP. There was considerable redundancy in documentation, with duplicate notes in the integrated progress notes and in the activity plan format. Additionally, a new Activity Plan was printed each month, though the form was designed for three months (i.e., one quarter's worth of data). There was inconsistency in the rationales provided to continue or discharge from services.

#	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.	<u>Current Staffing</u> At the time of this onsite review, Brandie Howell, OTR continued to serve as the Habilitation Therapies Department director. OT/PT staffing was consistent with the previous review. Physical therapists included Wilfredo Diaz, PT, Sandra Opersteny, PT (also served as the Assistant Director of Habilitation Therapies and on the PNMT), Candy Quieng, PT, Jeffrey Ronquillo, PT, Gloria Miller, DPT, Betty Cotton, PTA, Linda Harwell, PTA and Teresa Wheeler, PTA. OTs included Sheila Michael, OTR, Doris Ricketts, OTR, Harvey Evans, DOT, Christopher Ross, OTR (also served on the PNMT), Candice Drews, COTA, Lisa Finley, COTA, Karen Fleming, COTA, and Pamela Harlan, COTA (also supervised PNMTs). Many of the contract staff present at the time of the previous review had extended their contracts and continued to provide services at MSSLC at the time of this current review. That was a commendable achievement and efforts to continue to retain this level of staffing is encouraged. At the time of this review, the census at MSSLC was 390 individuals. Only four OTs and four PTs were available for direct supports (Ms. Opersteny and Mr. Ross were assigned other duties). The reported number of individuals with PNM needs was 274 or 70% of the total census. There were five professional staff (one PT, two OTs, and two COTAs) who were not assigned a specific caseload relative to provisions of annual assessments, intervention and monitoring, though they were assigned other duties. They should not be included in the calculation of staff to individual ratios. The assistants were not licensed to complete assessments and design interventions supports and, as such, were also not included in these ratio calculations. Their roles were critical, however, in that they were to provide training, supervision of technicians and PNMPCs, assist with data gathering, provide monitoring, and provide direct/indirect supports. Given that, ratios based on the current census were approximately 1:97.5 (PT) and 1:195 (OT) and approximately 1:68.5 (PT) and 1:137 (OT) based on the number of individuals with identified PNM needs. These ratios, particularly for OT, were too high to ensure adequate provision of necessary supports. There was one PT technician and one OT technician, plus 12 PNMPCs. There were four wheelchair technicians, though there would only be three as of 4/1/12, by report. These positions had been relatively stable over the last six months, however. <u>Continuing Education</u> All OT/PT staff were listed as participating in continuing education since the previous review with the exception of Lisa Finley, COTA. Much of the continuing education was related to wheelchair and seating. Eight staff had attended the DADS-sponsored	Noncompliance

#	Provision	Assessment of Status	Compliance
		Habilitation Conference held in October 2011. Although supporting continuing education may be difficult to justify for the clinicians who fill short term contracts, the facility is commended for promoting this for the current contract staff. Additionally, it will continue to be important that all clinicians be supported to attend PNM-related continuing education opportunities beyond that offered by the state to ensure that they expand their knowledge and skills. <u>New Admissions</u> There were 24 individuals newly admitted to the facility since the last onsite review. Nineteen of them were listed as receiving an OT/PT assessment within 30 days of admission, though it was rated as 100% in the MSSLC self-assessment. <u>OT/PT Assessments</u> A new comprehensive assessment format was reported to be in use at the facility and included assessment by OT and PT. The outline submitted included medical history, medications, behavioral concerns, and other current health issues that would impact the delivery of OT and PT services. Risk levels at the time of the assessment were not reported. The assessment included physical assessment of sensory/motor/neuromuscular systems and functional motor and daily living skills performance. Physical Nutritional Management issues related to positioning supports, mealtime, medication administration, and oral care were also addressed. The outline also included sections to address the clinicians' analysis of findings (summary, strengths and needs), recommendations, measurable outcomes, interval for reassessment, and factors for community placement. Assessment audits were planned and these results will be a focus of the monitoring team during the next onsite review. No templates for baseline or baseline updates were submitted. It was unclear what the difference was between the baseline and comprehensive assessment and it appeared that the baseline update also served as an update to comprehensive assessments as well as baselines. The five most current assessments for each clinician and current individual ISPs were requested by the monitoring team for review. Though a number of assessments and ISPs were submitted, many were duplicated unnecessarily. Others were included in additional requests. Thirty-four unique assessments were submitted, and included 22 baseline update assessments, one baseline assessment and 11 comprehensive assessments. Additional OT/PT assessments were included for individuals in the sample requested by the monitoring team (20 of 22 were submitted) though assessments for only 18 of those were considered current within the last 12 months. The assessment for Individual #304 was incomplete. Individual #562 had two current updates assessments dated 12/2/11 and 1/2/12. The assessment for Individual #272 was dated 6/22/10 and the assessment	

#	Provision	Assessment of Status	Compliance
		for Individual #229 was dated 10/28/10. No assessments were submitted for Individual #369 or Individual #477. Four of the assessments were Comprehensive OT/PT assessments, one was a Baseline Assessment, and 13 were Baseline Update Assessments. Assessments for individuals listed as participating in direct OT and/or PT services were also requested for eight individuals. The assessment for Individual #570 was dated 1/21/11 and was not current within the last 12 months (as would be expected for an individual participating in direct therapy). Three others were duplicated in other requests. The remaining four assessments included OT/PT Comprehensive Assessments (2), and Baseline Update Assessments (2), each current within the last 12 months. The total number of assessments reviewed was 56. Comments by the monitoring team on these 56 assessments follows below: • 30% (17/56) were identified as comprehensive assessments. o 0% of these were consistent with the template Comprehensive Assessment format submitted as current. • 100% (56/56) of the assessments were dated as completed prior to the annual ISP meeting, though some were done only the day before (Individual #314, Individual #222, Individual #38, and Individual #151) and others less than a week prior to the ISP (Individual #449, Individual #361, Individual #435, and Individual #120). • 100% (56/56) identified the date of the previous assessment(s). • 95% were signed copies of the original, though all had undated signatures. The date of assessment was consistently identified, though it was not possible to determine when the report was finalized and signed and, thereby, available to the IDT for review and integration into the ISP • 80% included a section that reported health risk levels. Some of these reported only high risk concerns and other reported both high and medium risk levels. There was no evidence that this information was utilized for planning interventions and supports and recommendations for changes to the existing risk levels were not addressed in any of the assessments reviewed via an analysis of findings. One example was Individual #56, who was listed at high risk for falls and polypharmacy and medium risk for weight and dental. The data section of the report indicated that he was actually at low risk for falls per the Tinetti Balance Assessment Tool. He used a wheeled walker and was deemed safe and independent on level and uneven terrain. It was reported that he had no documented falls in the last year. There was no discussion of the effectiveness of the supports provided in the prevention of falls nor was there any discussion that perhaps the high risk designation was not an accurate one. There was no discussion of the potential for polypharmacy effects on balance and coordination. Further there was no discussion of his weight, or description of what his weight	

#	Provision	Assessment of Status	Compliance
		issues were or whether there was a need for an exercise program to assist with weight management. Though dental was listed as a concern, toothbrushing was not mentioned under ADLs. • 0% included an analysis section and, as such, there was no rationale offered for the interventions and supports recommended. There was no consistent place to reference to determine if the existing supports had been effective over the last year. Eleven assessments had very brief summary sections, but none qualified as an acceptable analysis of findings to identify changes in status, potentials for skill acquisition, needs or barriers. These are essential elements of an analysis to ensure appropriate rationale for determining appropriate interventions and supports. • 100% included a Recommendations section. • 16% included suggestions for direct therapy and/or SPOs for implementation in the home or through OT/PT. The goal was not stated, but rather a general category of intervention, such as improving gait or range of motion. • 78% included a monitoring schedule via Activity Plans. There was no rationale for these, and each was identified as quarterly by the therapy clinician. There was no recommendation as to the needed frequency of other PNMP monitoring by the therapists, IDT or PNMPCs. There was no evidence that level of health risk was considered to drive the frequency of monitoring for individual status, effectiveness of supports and interventions or related to implementation of the PNMP. • 100% included a reassessment schedule. • 0% included factors to consider for placement in a community setting. • 95% of the ISPs submitted with the assessments were current within the last 12 months. • 54% of the ISPs were attended by OT. • 62% of the ISPs were attended by PT. There were no sections of the assessments that identified any personal outcomes, goals, or skills to be taught, such as what might have been taken from each individual's Personal Focus Assessment, from the data collected in the OT/PT assessment or from the ISP's strengths, challenges, and preferences. • Individual #72: Per his assessment dated, 10/20/11, he had a prior humeral fracture for which OT was provided to the left shoulder and elbow. At the time of discharge from therapy his shoulder flexion was 93 degrees and left elbow extension 68 degrees. It was recommended that his PNMP, Dining Plan, and adaptive equipment be evaluated annually, though another recommendation indicated that he would not be re-evaluated until 2014.	

#	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.	<u>OT/PT Interventions</u> The primary intervention provided was the PNMP. These were addressed in detail in section O above. Other OT/PT via direct PT was provided for only a small number of individuals (Individual #570, Individual #449, Individual #84, Individual #293, Individual #361, Individual #444, Individual #160 and Individual #427). Documentation was inconsistent related to these direct services. • Baselines, or need for therapy interventions, were not established in an assessment (Individual #570, Individual #449, Individual #427, Individual #293, Individual #444, Individual #361, Individual #84, Individual #341). Individual #293 was listed as participating in OT/PT program for walking and this was referenced in his OT/PT assessment and ISP, but there was no documentation submitted related to this service. • Measureable goals for direct OT or PT were not included in the ISP or addendum (Individual #449, Individual #427, Individual #160, Individual #293, Individual #444, Individual #361, Individual #570, Individual #341). There was insufficient justification to initiate, continue or discharge individuals from direct therapy (Individual #449, Individual #427, Individual #160, Individual #293, Individual #84, Individual #570, Individual #341). • The introduction of direct therapy was not addressed in the annual ISP or via an ISPA when the need was identified in the interim (Individual #449, Individual #427, Individual #84, Individual #570). • Change in status was not consistently addressed via an assessment and ISPA (Individual #444, Individual #84). Individual #444's program indicated that she was to be seen twice weekly for a walking program that had been reinstated as of 12/22/11 per an ISPA. However, between 12/22/11 and 2/28/12, for which documentation was submitted, she was seen only seven times. Rationale for failure to provide this intervention at the prescribed frequency was not documented. There was no documentation after 2/23/12 related to this plan. • Documentation was inconsistent and did not close the loop regarding the status of direct therapy provided, the individual's progress toward functional goals, or other status (Individual #449, Individual #427, Individual #160, Individual #293, Individual #444, Individual #84, Individual #570). • Documentation of actual interventions was generally consistent, however, this was often duplicated in the integrated progress noted as well as in the Activity Plans or SPOs (Individual #341, Individual #188, • OTs and PTs did not consistently complete a post-hospitalization assessment for individuals upon return to MSSLC or for other changes in status (Individual #266, Individual #341). • Occasional issue-specific assessments were noted as documented in the integrated progress notes. The assessments were not comprehensive, however.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The therapists appeared to more consistently address referrals from physicians. As described above, findings were often not integrated into the ISP.	
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.	Competency-Based Training Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs was addressed in detail in section O above. No evidence of competency-based training for the implementation of OT- or PT-designed programs by therapy technicians or by direct support staff was submitted to the monitoring team.	Noncompliance
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 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.	Monitoring A system of monitoring of the PNMPs, and the condition, availability, and effectiveness of physical supports and adaptive equipment was implemented at MSSLC and addressed in section O above. Recommended frequency of monitoring was not included in the OT/PT assessments other than reference to Activity Plans for quarterly monitoring of assistive equipment. Frequency or interval of monitoring conducted by the PNMPCs was not identified in the assessments and findings of the monitoring conducted were not reported in the OT/PT assessments in an effort to determine efficacy of the interventions previously recommended and implemented. There was no consistent method used to document progress related to OT/PT interventions via SPOs. Although some progress notes, discipline specific assessments, weekly progress notes, datasheets, and monthly summary notes were in the records submitted, these were not consistent across the records reviewed. While there were measureable goals in some cases, the documentation related to these interventions was inadequate in providing sufficient data and comparative analysis of progress from month to month. There was also inconsistent justification to continue or discontinue the interventions. Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT were included in the routine monitoring of the PNMPs as described above in section O. There were no routine maintenance checks documented to assess the working condition of the wheelchairs, gait trainers, and adapted chairs, other than the PNMP monitoring conducted by PNMPCs. It appeared that responses to requests for repairs, however, were completed in a timely manner. Staff were responsible for cleaning the equipment and this was reviewed by the PNMPCs as well. A log of work orders was generated and tracked for completion and timeliness with orders generated through routine PNMP monitoring, random checks, and reports by direct support and home	Noncompliance

#	Provision	Assessment of Status	Compliance
		management staff.	

Recommendations:

1. There was a continued need to develop programs to address increasing or expanding functional skills. 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. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (P1 and P2).

2. Initiate assessment audits to ensure improvement and consistency with the new format and expected content (P1).

3. The assessments should consistently include a review of the efficacy of existing supports and services with concrete justifications for these and all other recommendations in the analysis section (P1).

4. Include oral hygiene status in OT/PT assessments not only positioning. Consider strategies to address sensory issues that may negatively impact the effectiveness of oral hygiene care (P1).

5. Conduct consistent post-hospitalization assessments for high risk individuals and other PNM-related concerns. Establish guidelines for when a comprehensive assessment was indicated (P1).

6. Documentation of direct therapy services should state a clear rationale to continue the service, modify the plan or discharge. Measureable goals should be clearly stated and integrated into the ISP. Data collected should link to the expected outcomes and progress notes should summarize progress. Close the loop (P2).

7. Implementation of coaching and skills drills with staff was 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 (P3).

8. Implement a strong training curriculum as soon a s possible for the PNMPCs. Do not wait for elaborate materials to do so, however, just begin to provide content information in a variety of areas useful to their understanding of their role as a monitor, coach and model for direct support staff.

9. Conduct routine validation of monitoring and training completed by the PNMPCs and home supervisors (P4).

10. Review the current system for documentation. Eliminate redundancy and ensure that the information is readily accessible to all team members in the individual record. The clinicians have much to do and all documentation should be critical and necessary so they can focus on active supports and services to individuals and on staff training.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, 8/17/10 o MSSLC Dental Services 01 Dental Philosophy, 9/16/11 o MSSLC Dental Services 02 Dental Services, 9/16/11 o MSSLC Oral Hygiene Care, 8/3/11 o Procedure for Suction Toothbrushing, undated o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o MSSLC Section Q Self-Assessment o MSSLC Section Q Action Plana for Section Q o MSSLC Section Q Presentation Book, Dental o MSSLC Organizational Chart o Dental records for the individuals listed in Section L o Desensitization plans for the following individuals: • Individual #160 o Emergency Treatment documentation for the following individuals: • Individual #261, Individual #300, Individual #420 Individual #324, Individual #309 Individual #142 Individual #268, Individual #17, Individual #100, Individual #379, o ISP Addendums for the following individuals: • Individual #560, Individual #470, Individual #506, Individual #49, Individual #1 Interviews and Meetings Held: o John Sponenberg, DDS, Dental Director o Jimmy Tompkins, DDS, Staff Dentist o Dolores Erfe, MD, Medical Director o Vicki Simmons, RDH o Rose Groth, RDH o Melinda Lopez, RDA o Sandra German, Administrative Assistant o Brandie Howell, OTR, Habilitation Therapies Director Observations Conducted: o Dental Department o Informal observation of oral hygiene regimens in residences

	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) a list of completed actions. For the self-assessment, the facility described for both provision items, a series of activities engaged in to conduct the self -assessment, the results of the self-assessment, and a self-rating. This was a great improvement in the assessment process. During the week of the onsite review, the monitoring team met with the entire dental clinic staff to discuss the self-assessment process. Most appeared eager to understand and realized that the process was valuable in helping the facility to move towards substantial compliance. To take this process forward, the monitoring team recommends that the dental director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in noncompliance with both provision items. The monitoring team agreed with the facility's self-rating.
	Summary of Monitor's Assessment: Progress was noted in the provision of dental services. A second dentist had been working at the facility for several months and a full time administrative assistant joined the department in October 2011. This allowed the dental director some time, in fact the majority of his time, to focus on the Settlement Agreement. The statewide database was scheduled to be implemented in April 2012 and the clinic staff appeared eager for this to occur. The facility continued to provide basic dental services onsite, while more advanced services were provided at a local hospital. Sedation and general anesthesia were not used at MSSLC and there was no plan to do so. Oral hygiene ratings improved, but very few individuals had good oral hygiene. Most had fair hygiene and individuals with poor or fair hygiene were required to have monthly clinic visits. The facility did not have a structured home oral care program. All staff were trained on the provision of oral care during pre-service training, and the dental clinic staff conducted pre-service training. A few individuals received suction toothbrushing. That program was under the purview of the habilitation department. More individuals needed to be identified for this treatment.

	Annual assessments were completed with some minimal deficiencies noted. The facility opted to implement more stringent guidelines as a measure of remediation. Documentation improved due to the use of electronic charting, but the department will need to revaluate the format. Nonetheless, this was a great improvement because the records were legible. IPN entries were in SOAP format with the exception of notes pertaining to emergency visits. The facility continued to struggle with failed appointments. Approximately 20% of appointments failed over the six months prior to the onsite review. Missed appointments occurred because of staffing issues, off campus trips, and other medical appointments. There continued to be issues with refusals. These barriers prevented care that ultimately contributed to declining oral health.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q1</td><td>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.</td><td>The dental clinic staff was comprised of a dental director, staff dentist, two registered dental hygienists, and two dental assistants. An administrative assistant joined the department in October 2011 and was instrumental in organizing the department. The dental director reduced his clinical activities to approximately two hours a week. A facility with a census of 390 was essentially staffed with one full time dentist. Dental clinic was conducted five days a week from 8:00 am until 5:00 pm.

<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. Data related to the provision of dental services were collected. Those data are summarized in the table below.

<table>
<tr><th colspan="7">MSSLC Dental Clinic Appointments 2011- 2012</th></tr>
<tr><th></th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th></tr>
<tr><td>Preventive</td><td>175</td><td>208</td><td>171</td><td>150</td><td>225</td><td>187</td></tr>
<tr><td>Restorative</td><td>68</td><td>25</td><td>48</td><td>44</td><td>61</td><td>52</td></tr>
<tr><td>Emergency</td><td>10</td><td>8</td><td>9</td><td>12</td><td>19</td><td>19</td></tr>
</table>

The records of the individuals included in the record sample indicated that most were seen in dental clinic in a timely manner. The individuals received preventive care and restorative care when indicated and possible. Many had significant aspiration risk, but recommendations for suction toothbrushing were not usually noted. Documentation of oral hygiene instructions being provided to the staff and individuals was noted in every record. Most were on frequent recall due to fair or poor hygiene ratings.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Emergency Care 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. A sample of 10 emergency records was examined. Care appeared to be timely. All entries note the oral hygiene status of the individual. Generally, the care appeared appropriate. Documentation, however, was not adequate. They stated "Rx written," but did not indicate what medication was prescribed. It was also not always clear that individuals received adequate analgesia. Since the dental director was no longer actively involved in patient care, it is important that he review records to ensure that the care provided and the documentation of the care is appropriate. None of the emergency IPN entries were in SOAP format. Oral Surgery Several individuals required more advanced treatment at Scott and White Hospital. The numbers of individuals receiving treatment are summarized below.	

Community Dental Appointments 2011- 2012						
	Sept	Oct	Nov	Dec	Jan	Feb
Consultation	2	3	9	1	1	1
Oral Surgery	0	3	7	2	1	0

The facility provided a list of those individuals, but the list usually lacked detail about the type of treatment. Copies of the consultations were not provided for all of the individuals on the list. Several of the oral surgery consults that were provided described individuals with multiple decayed teeth that were beyond restoration. Most of the consults indicated that the individuals had refused dental treatment in the past or otherwise had been difficult to treat.

The facility needs to have some process for assessing the longitudinal care of individuals who are having full mouth extractions and multiple decayed teeth to determine if the deterioration of dental status occurred during the time of admission at the facility. Individual #484 had a history of refusing dental appointments. Refusing dental treatment likely resulted in the deterioration of his dental health, so it would be important to know what interventions and strategies were implemented by the IDT to overcome barriers to dental treatment.

#	Provision	Assessment of Status	Compliance
		Oral Hygiene At each visit, oral hygiene instructions were provided to the individual or the staff that accompanied them. The hygiene ratings for every individual were entered into a spreadsheet and these data were sent to the home managers. Oral hygiene data are summarized in the table below. Oral Hygiene Ratings 2010 - 2011 Quarter / Poor % / Fair % / Good % 1st: 10 / 49 / 41 2nd: 9 / 48 / 43 3rd: 7 / 60 / 33 4th: 4 / 57 / 39 Based on these data, there was an overall improvement in oral hygiene ratings because the percentage of poor ratings was decreasing. Record audits revealed that most individuals had fair hygiene scores and almost every individual was noted to have some calculus or debris at the time of examination. The monitoring team made a previous recommendation to develop a plan to improve oral hygiene campus wide. The clinic staff reported that individuals with fair and poor hygiene ratings were placed on one- to two-month recalls to improve oral hygiene. This approach produced some improvement. The monitoring team suggests that the facility give consideration to a more home based oral care program. The dental hygienists currently providing some home care, approximately two hours twice a month. Four individuals were receiving suctioning toothbrushing by their primary therapy teams. Individual #518 was included in the record sample and documentation of this treatment was noted. Another individual with recurrent aspiration pneumonia was having a trial assessment by the PNMT for suction tooth brushing. Staff Training All direct care professionals 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. The facility provided a training roster that included the names of 954 staff that completed annual training. While it was good to see such a large number of staff completing training, the facility should provide data on what percentage of staff required to complete training had actually completed the training.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.</td><td>Policies and Procedures
The dental clinic had localized the state issued dental services policy since the last onsite review had had documentation that all staff had been inserviced on the requirements of the policy.

Annual Assessments
In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months along with the date of previous annual assessment was requested. Assessments completed by the end of the anniversary month were considered to be in compliance.

<table>
<tr><td colspan="7">Annual Assessment Compliance 2011 - 2012</td></tr>
<tr><td></td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td></tr>
<tr><td>Exams Completed</td><td>23</td><td>28</td><td>46</td><td>39</td><td>89</td><td>58</td></tr>
<tr><td>Compliant Exams</td><td>20(87%)</td><td>28(100%)</td><td>42(91%)</td><td>36(92%)</td><td>79(89%)</td><td>52(90%)</td></tr>
</table>

Initial Exams
The facility submitted a list of individuals admitted to the facility along with the dates of the initial dental examination. This list was compared to the facility's admissions listing. Twenty eight individuals were admitted from September 2011 to February 2012. Twenty five of 28 (89%) individuals had initial exams completed within 30 days of admission.

Dental Records
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 ISPs and direct readers to the dental treatment records contained within the active records. The notes were dated, timed, and signed. Since the last onsite review, a significant improvement was noted in the legibility of the records since all were electronically generated.

Failed Appointments
The clinic schedule was usually distributed one week in advance of clinic. It was distributed to the homes, transportation departments, and clinics. Each morning, the units were informed of the day's appointments. Data were collected on failed appointments and distributed each month to the QDDPs, residential staff, and the residential supervisors. The data provided by the facility are summarized in the chart below.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance

Failed Appointments 2011 - 2012						
	Sept	Oct	Nov	Dec	Jan	Feb
Refused	31	37	20	19	28	16
Missed	31	50	43	53	42	45
Failed	62(19%)	84(23%)	63(20%)	72(25%)	69(19%)	61(20%)
Total Clinic Appointments	335	365	318	284	367	298

The facility continued to have problems with missed appointments. Reasons for missed appointments included off campus trips, other medical appointments, and staffing issues. The dental clinic staff also reported problems with individuals being 30 or more minutes late for clinic appointments and records not being brought to clinics for appointments. All of these factors contributed to failed appointments. These were discussed in the morning unit meetings, but the dental director did not believe this approach was working. The clinic staff also expressed that they did not believe the direct care professionals felt fully accountable for getting individuals to clinic in a timely manner due to staffing issues.

<u>Dental Restraints</u>
The dental clinic did not use any mechanical restraints nor did it use any pretreatment sedation.

<u>Strategies to Overcome Barriers to Dental Treatment</u>
The monitoring team requested evidence that the IDTs reviewed, assessed, developed, and implemented strategies to overcome refusal of treatment. Four ISP addendums were submitted for review.

- Individual #560 refused dental treatment. The ISPA dated 9/15/11 indicated that the individual required oral surgery. There was no strategy in the plan that would result in the outcome of competing surgery and no follow-up ISPA. The oral surgery tracking list did not indicate that the individual had surgery as of February 2012. The individual refused MSSLC dental services in December 2011, January 2012, and February 2012.
- Individual #470 refused dental services. The ISPA dated 10/10/11 stated the individual stayed up all night and wanted to sleep all day and, therefore, needed counseling. The individual subsequently refused dental services in October 2011, December 2011, January 2012, and February 2012. There was no follow-up ISPA submitted.
- Individual #49 refused to go to clinic. The ISPA dated 3/7/12 indicated that a preferred staff member that worked well with the individual would accompany the individual. This appeared to be a perfectly reasonable first step.
- Individual #1 refused multiple dental appointments. The ISPA dated 10/6/11

#	Provision	Assessment of Status	Compliance
		indicated that the team discussed various ways to overcome barriers to treatment. The result was that the dental directors recommended that the individual be placed on a dental desensitization plan. The request was sent to psychology. There was no documentation of any follow-up to the recommendation. <u>Desensitization</u> The facility implemented a Desensitization Committee that held its initial meeting in early March 2012. The dental director reported that psychologists had developed four desensitization plans, but only one was submitted to the monitoring team. The dental clinic staff was documenting at each appointment, when indicated, the need for consideration of a formal desensitization plan. The desensitization plan for Individual #372 appeared appropriate was based on a functional assessment and was individualized. It was implemented on 12/27/11, but no information was provided on the status of the plan at the time of the on site review. (Also see comments in section S1 regarding desensitization plans.) Overall, the facility continued to lack a system to address problems with refusals. The dental clinics approach was to place individuals who refused clinic on one month recall increasing the chance of a successful clinic appointment.	

Recommendations:

1. As the department becomes more organized, the dental director should return to more clinical duties (Q1).
2. The dental director must ensure that all IPN documentation is made in SOAP format. Documentation should be through, complete, and meet professional standards (Q1).
3. All individuals who have the potential for pain should have an appropriate pain assessment completed and documented to ensure than adequate analgesia is achieved (Q1).
4. The appropriate risk assessment should be completed and recommendations made when appropriate for suction toothbrushing (Q1).
5. The clinic staff must take a more active role in training the direct care professionals in the ongoing provision of oral care (Q1).
6. The facility should consider developing a home based oral care program that includes more involvement of the direct care professionals as an alternative to having individuals come to clinic every month (Q1).

7. The facility must address the issue of missed appointments and determine how to further decrease this problem (Q2).

8. The issue of refusal must be considered a priority as individuals who continue to refuse appointments experience declining oral health including rampant oral decay. The facility must develop a systematic approach to this problem including mechanisms to develop strategies and interventions to overcome barriers to dental treatment (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:** **<u>Documents Reviewed</u>:** o Admissions list o Budgeted, Filled, and Unfilled Positions list o Speech Staff list o SLP Continuing Education documentation o Section R Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section R-Communication Guidelines o Settlement Agreement Section R: Audit forms submitted o Performance Evaluation Team Monthly Provision Action Information Worksheet Section R o Habilitation Therapy Services Assessment Evidence Speech o Integrated Skill Acquisition Program Curriculum Process guidelines o Speech Therapy Services (SPOs, Programs, Activity Plans) o Augmentative and Alternative Communication Profile o Speech Language Communication Assessment template and guidelines o Individuals with Behavioral Issues and Coexisting Language Deficits o Individuals with PBSPs and Replacement Behaviors Related to Communication o Individuals with PBSPs o Augmentative Communication spreadsheet o List of individuals receiving direct speech services o Communication Master Plan Database o Communication Dictionaries and Activity Plans for monitoring as submitted o Communication Assessments for individuals recently admitted to MSSLC: • Individual #124, Individual #393, Individual #174, Individual #90, and Individual #529. o Communication Assessments, ISPs, ISPAs, SPOs, and other related documentation for the following individuals receiving direct speech services: • Individual #455 o Communication assessments and ISPs for the following: • Individual #143, Individual #94, Individual #165, Individual #321, Individual #595, Individual #224, Individual #66, Individual #169, Individual #152, Individual #444, Individual #72, Individual #296, Individual #447, and Individual #491. o PNMPs submitted o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, 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 #432, Individual #477, Individual #533, Individual #120, Individual #229, Individual #222, Individual #435, Individual #542, Individual #84, Individual #61, Individual #369, Individual #341, Individual #524, Individual #304, Individual #562, Individual #272, Individual #427, Individual #446, Individual #151, Individual #188, Individual #518, Individual #266, and Individual #229. o PNMP section in Individual Notebooks for the following: • Individual #432, Individual #477, Individual #533, Individual #120, Individual #229, Individual #222, Individual #435, Individual #542, Individual #84, Individual #61, Individual #369, Individual #341, Individual #524, Individual #304, Individual #562, Individual #272, Individual #427, Individual #446, Individual #151, Individual #188, Individual #518, Individual #266, and Individual #229. o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #432, Individual #477, Individual #533, Individual #120, Individual #229, Individual #222, Individual #435, Individual #542, Individual #84, Individual #61, Individual #369, Individual #341, Individual #524, Individual #304, Individual #562, Individual #272, Individual #427, Individual #446, Individual #151, Individual #188, Individual #518, Individual #266, and Individual #229. <u>Interviews and Meetings Held</u>: o Brandie Howell, OTR, Habilitation Therapies Director o David Ehrenfeld, MSEd, CCC/SLP o Frances Harman, MS, CCC/SLP o Charlese Turner, MS, CCC/SLP o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas, dining rooms, day programs
	Facility Self-Assessment: MSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. The Presentation Book for R provided information related to actions taken, accomplishments, and work products.

	The facility was to describe, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, and documentation of the results of the self-assessment. The activities listed did not actually represent actions that assessed the status of compliance with the provision items but rather merely listed documents reviewed or general activities, such as in the case of R1, "reviewed the current staff." The results reported were limited to numbers and percentages of items completed. For example, for R2, 55 or 100% of Annual Comprehensive Assessments were reported as completed, and 37 or 100% Annual Update Assessments completed. It was not known in what time frame these were completed and clearly these numbers did not represent the number of assessments for the total census reported by the facility (390). Additional percentages were reported, but there was no clarity as to how those listed provided assessment of compliance. In all cases, there was no statement of what the "universe" was and, in many cases, the data conflicted. The Habilitation Therapy Services Director had clearly read the previous monitoring report and was attempting to respond to many of the recommendations and comments in that report. This was a great step in planning for self-assessment and the development of action plan. In most cases, however, data were merely reported, but not in a context of assessment or to provide analysis. In some cases, the data were reported in a manner different from that in the monitoring report. It will be important for the department director to understand the somewhat subtle difference between assessing whether substantial compliance was met versus engaging in activities to meet substantial compliance. The statewide self-monitoring tool may be one of the activities used to self-assess, but will not likely be sufficient for most provision items and the action plans may not always address everything that needs to be addressed. The monitoring team conducted a lengthy discussion with the department director regarding approaches to the self-assessment process and it is hoped that this provided a clear direction for the future. The facility self-rated itself as not in compliance with each of the provision items of section R. Actions taken were definite steps in the direction of compliance, but the monitoring team concurred with noncompliance for R1 through R4.
	Summary of Monitor's Assessment: Staffing levels were decreased at the time of this review and it is hoped that these levels can be increased through the planned recruitment efforts. As always, the SLPs were responsible for communication supports and mealtime supports for all of the individuals living at MSSLC. These dual roles made the current ratios quite high, reported as 200, 42, and 127 for three clinicians, respectively. There were no SLPAs at the time of this onsite review, though there were three vacant positions. In addition, one clinician served as a member of the PNMT and participated on the BSP Committee, thus reducing her availability for routine caseload responsibilities, leaving most of that to only two other clinicians. Progress with completion of comprehensive communication assessments per the Master Plan was unclear based on the documentation submitted. Timeliness of completion of assessments appeared to be improved with more assessments completed prior to the ISP, most at least two weeks before the meeting, though

	25% were completed after the ISP. While efforts had been made to ensure improvements in the assessments, there continued to be problems with those reviewed. Having appropriate content in the sections that address AAC and analysis of findings will be key to achievement of compliance in section R. The clinicians continued to report difficulties with implementation of AAC related to maintenance and consistent use throughout the day. There were Communication Instructions that included use of an AAC or environmental control device for only five individuals. These instructions sheets provided operation and cleaning instructions, but there were no specific instructions to describe how the device was to be used with the individual. The limited number of these, and the lack of individualization for the existing plans, likely contributed to the lack of consistent use by staff. A number of systems were recommended in the communication assessments, but without ongoing and consistent support provided by speech clinicians. This should not be the sole responsibility of direct support and day program staff. 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.	Staffing: At the time of this review, there were three full time SLPs: David Ehrenfeld (Barnett, Whiterock and Longhorn), Frances Harman (Martin 5-8 and PNMT), and Charlese Turner (Martin 1-4 and Shamrock). Only one of these clinicians was a state employee. Caseloads were reported as 200, 42, and 127, respectively. There were no SLPAs at the time of this onsite review, though there were three vacant positions. This was a decrease in staffing since the previous review due to three resignations (one SLP and two SLPAs), plus the caseloads were significantly high. There were six speech positions listed with two filled, two contract therapists, and four unfilled positions. FTEs were listed at two, as of 2/29/12 and the therapist to individual ratio was 103. This was unacceptably high particularly given that SLPs were responsible for both communication and mealtime concerns for each of the individuals. Ms. Harman also served as the SLP on the PNMT, in addition to her assigned caseload in Martin. These factors impacted the operational ratio for speech services. Interviews for SLPs had been conducted and an additional SLP was to begin on 4/16/12. Brandie Howell, Director of Habilitation Therapy, reported that there were positions for five SLPs. With the addition of the newly hired therapist, she indicated that this would leave only one SLP vacancy and she identified three vacancies for SLPAs. A recruitment plan was reported to be in development that included a state recruiter position to assist with the problem of recruitment of qualified candidates. The monitoring team is hopeful that this issue can be addressed, but understands that recruitment and retaining of	Noncompliance

#	Provision	Assessment of Status	Compliance
		therapy staff is an ongoing concern. <u>Continuing Education</u> There was no reported continuing education specifically related to communication attended by the SLPs since the previous review. Ms. Harman and Ms. Turner attended the State Habilitation Therapy conference in October 2011, though it was not known how much of that pertained to communication versus physical nutritional management issues. Each clinician had listed continuing education related to assistive technology attended in the last year (June 2011). Participation in communication-related continuing education during this last review period appeared to be limited. Continued participation is critical to ensure improved clinical assessment and program development skills for AAC and language for individuals with developmental disabilities.	
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.	The Master Plan was dated 3/7/12. Individuals were prioritized at three levels based on their needs for AAC as follows: • Priority 1: 54 • Priority 2: 64 • Priority 3: 26 Additional priority status designations listed in the Master Plan included UD (3), C (1), Complete (273), and New (22). Of those listed as complete, there were 213 individuals listed as verbal and 53 listed as nonverbal. There was no communication status identified for those listed as New, while those designated C and UD were identified as verbal. The communication status of seven others was not listed. Of those listed as Priority 1, all were identified as nonverbal with the exception of three individuals who were identified as verbal (Individual #301, Individual #548, and Individual #63). Of those listed as Priority 2, 51 were identified as nonverbal and 13 were identified as verbal. All the individuals listed as Priority 3 were identified as verbal. It was not clear, based on this database, whether assessments had been completed for the individuals listed. If one were to assume that the designations of Complete, New, UD and C identified those with completed Communication Assessments, it would appear that approximately 144 individuals still required an assessment. There were a number of individuals (approximately 125) who had been provided communication evaluations per the Habilitation Therapy Services Assessment Evidence - Speech. These assessments had been done since the previous monitoring review in September 2011. Five individuals were provided two assessments during that time. A	Noncompliance

#	Provision	Assessment of Status	Compliance
		number of these individuals (23) had not been included in the Master Plan. Nearly half were not identified as complete in the Master Plan. There was no key provided in either document to identify designations used, though it appeared that C referred to Comprehensive Assessments (35), UD referred to Update Assessments (52), and B referred to Baseline Assessment (25) for individuals newly admitted to MSSLC. Only the Master Plan was dated. Eighteen others were identified as CLDP assessments. These databases were inconsistent in the data they presented. Even so, there appeared to be at least 92 assessments incomplete based on the designations in the Master Plan, 3/7/12, and the tracking log of assessments. Although this showed good progress, it was of concern to the monitoring team that approximately 36% of these were individuals of the highest priority level and, as such, with the greatest potential need for AAC or other communication supports. The Master Plan did not provide information as to when the previous assessment had been completed, whether they were updates or comprehensive assessments, or when the subsequent assessment was due. All of the assessments listed since the previous review were identified as completed prior to the ISP with two exceptions (Individual #477 and Individual #219). Each of these was listed as completed on the day of the ISP, which is not adequate to ensure appropriate review and implementation of the information and/or recommendations by the IDT. Due dates for assessments were listed two weeks prior to the ISP meeting date. At least 25% of the assessments listed were completed <u>after</u> the due date. Assessments for 16 individuals were submitted: the five most current for each therapist. Only one had been completed in the current year (Individual #533) on 1/20/12, nearly three months prior to this onsite review. Others were completed as long ago as six months in September 2011. None of these would be considered to be the most current assessments for the purpose of review. In addition, assessments for individuals included in the sample selected by the monitoring team for the sections O, P, and R were requested. Assessments were submitted for 20 of 22 individuals in this sample. No communication assessments were submitted for Individual #151 or Individual #188. Assessments for only 17 individuals were current within the last 12 months. Individual #229's most current communication assessment was dated 1/24/06, while the other two had expired in early March 2012. There were two assessments submitted for Individual #435. The assessments for Individual #533 and Individual #477 were duplicated in both requests. Ultimately, there was a total of 32 assessments available for review. These included Comprehensive Assessments (8), Baseline Assessments, and (7) Baseline Update Assessments (17).	

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		Assessment templates for these types of assessments were not submitted, as requested. A copy of the Augmentative and Alternative Communication Profile authored by Tracy M. Kovach, PhD was submitted, but it was not used in any of these 32 assessments. The comprehensive assessments submitted were of a similar format, though there were some variations noted across each. Baseline assessments and updates were of a similar format as the comprehensive assessment, therefore, it was unclear what the intended differences were among these. A Comprehensive Assessment template identified as "new" was in the section R Presentation Book. None of the assessments submitted for review, including those in the Presentation Book, however, used this format. Issues noted in the assessments reviewed relative to this template were as follows: • Diagnosis and Pertinent History: In most cases, the diagnoses were merely listed, but relevance to the assessment or impact on the individual's health or function was not stated. • Medical History: There was no medical history reported. The individual's health status over the last year was not addressed. • Medications: The relevance of medications were often not addressed .In most cases, the medications were listed with the purpose and, in other cases, general side effects were listed. In one case, it was merely stated that the medications may affect speech, language and swallowing, but did not describe how these areas might be affected (Individual #61). In some cases, medications were not addressed at all (e.g., Individual #524, Individual #524, Individual #435). • Behavioral Considerations and Communication History: There were considerable differences across assessments in the content in these sections. • Oral Motor Skills: These were addressed in most of the assessments, though it was not in the template in the Presentation book. • Augmentative/Alternative Communication and Assistive Technology: Related items in the Communication Audit (R3.1 and R2.2) were identified as being 100% in compliance. Of the 22 individuals identified as nonverbal or partially verbal in the 32 assessments reviewed by the monitoring team, only one assessment reflected any level of actual assessment for AAC and/or AT. Individual #165 was deemed, however, to not have a need for AAC because she did not have the ability or desire for representation (symbols to represent objects or actions) necessary for training to use a communication system. It was also stated that her attention span was too limited to participate in programming for AAC. She was, however, able to vocalize and point to get an object from staff such as balloons. This strongly suggested that this clinician did not have an understanding of the contemporary approach to communication supports. This approach purports that there are no prerequisites relative to	

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		AAC use. Instead, this assessment reflected an approach that focused on inherent deficits that could not be remedied, rather than a focus on strengths and potentials of a participation model of communication. • Most of the assessments indicated that AAC was not appropriate, but without assessment and sufficient rationale. For example, Individual #94 was deemed to not have a need for AAC merely because he was not interested. There was, however, no evidence that serious, routine, and consistent efforts had been made to promote use in the context of his daily activities. Others included Individual #84, Individual #272, Individual #477, Individual #266, Individual #446, Individual #369, Individual #524, Individual #427, Individual #61, and Individual #518. • Individual #321 was the only individual in the sample that had an AAC system, however, her method of communication was described as verbal (using words, short phrases and simple sentences). Staff reported that she could say, "Coke," "bed," and "gum" and that she only used the device to hear it rather than to make a request. There were no recommendations other than to monitor use, care, and condition of the device. • Environmental Control: There was no consistent assessment in this area. • Risk Levels: This was addressed in only 20 of the 32 assessments reviewed. Some listed only high risk levels whereas others addressed both high and medium risk levels. The guidelines required that the clinician not merely list the risks, but also describe supports and services to mitigate these, with rationale. This was not noted in any of the assessments submitted. • Clinical Impressions: The analysis sections of these reports were merely a summary of what was already stated in the report. The summary paragraphs did not provide a rationale for the recommendations or communication strategies identified by the clinicians. The rationale to justify no need for AAC was typically inadequate, particularly in cases where the individual was partially verbal (e.g., Individual #477, Individual #518). The clinicians appeared to base their decisions about the need for AAC on whether the individual responded appropriately to the equipment they was presented in an assessment arena rather than a consideration of potentials for increased participation in daily activities throughout the day. They also appeared to expect spontaneous initiation from the individual as a prerequisite to the provision of an AAC system, rather than recognizing the need to model communication strategies throughout the day during real opportunities. • Measurable Objectives, Reassessment Schedule and Factors for Community Placement: These sections were not present in any of the assessments submitted. The timeframe for reassessment was stated in 100% of the assessments, though this was included as a recommendation or included in the	

#	Provision	Assessment of Status	Compliance
		Information for the IACT and PNMP section of the report. The type of assessment and rationale were not identified. The assessments did not identify important life activities or inventory ways for greater meaningful participation in them. There was no indication that the clinicians identified preferences, likes, or dislikes. The communication strategies listed in the assessments were a first step in the process, but were often generic in nature. The responsibility for application of actual AAC use (generally in the form of switch devices) was left to the direct support staff or day program staff who had received very limited training (e.g., Individual #427). In some cases, the potential to use AAC was not addressed by the clinician. For example: • In the case of Individual #446, the therapist reported that she had previously been provided a Cheap Talk on the Go and that she had not been using the device and did not recognize it as a tool for meeting her needs (as if that was Individual #446's responsibility to do so) and as a result it was discontinued. There was no further AAC assessment to identify something that would appropriately meet her needs in the assessment dated 8/2/11. • There was no mention of AAC Assessment in Individual #524's assessment dated 4/7/11. • In the case of Individual #143, she had been provided a Super Talker device with an eight icon overlay. It was reported that the device was not used functionally and, as such, was discontinued. There was no assessment conducted to identify an alternative system. No measurable objectives were identified in any of the assessments submitted for review. There were three individuals listed with SPOs for direct intervention by a speech clinician, but one of these was not related to communication, but rather to oral intake. Only one individual was recommended for direct intervention (Individual #595). The clinician stated in his assessment dated 11/18/11, that the team should discuss the possibility of articulation therapy to address his lisp and articulation errors. There was no evidence that this was discussed during his ISP held on 12/1/11. There were no action steps or training/service objectives to address this issue. There were three individuals who received or had participated in a speech or communication program. A number of others were listed with activity plans (service objectives to monitor the Communication Dictionary (83) and/or AAC device (8). A number of others had environmental control units, not specifically related to communication. There were approximately 92 individuals with Communication Dictionaries. There were	

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		approximately 51 AAC devices for 29 individuals in addition to a communication dictionary, and two others with an AAC device only (Individual #215 and Individual #279). On another spreadsheet, it was noted that at least 20 of these (devices and dictionaries) for 16 individuals were discontinued, some as long ago as 2009. It was not clear from this documentation exactly what the provision of AAC was at MSSLC. There were a handful of others who appeared to have some type of environmental control device (though not necessarily communication-related). Again this was not clearly identified in the documentation submitted. The clinicians continued to report difficulties with implementation of these devices due to maintenance problems. There were Communication Instructions that included use of an AAC or environmental control device for only five of the individuals. These instructions sheets provided operation and cleaning instructions for these devices. There were no specific instructions, however, to describe how the device was used with the particular individual. The lack of individualization for the existing plans may have contributed to the lack of consistent use by staff. As previously stated, a number of systems were recommended in the communication assessments, but without ongoing and consistent support provided by speech clinicians. This should not be the sole responsibility of direct support and day program staff. There was no specific screening or assessment process for those with behavioral concerns and the potential need for AAC, even though the current comprehensive assessment had a content area to identify specific communication-related behavioral challenges. The guidelines indicated that the assessment should include observations of behavior, affect, responsiveness to the assessment, habits or mannerisms, and discussion of the PBSP and communication-related behavioral issues. In most cases, the clinicians merely stated whether there was a PBSP only. There were 22 individual with PBSPs and replacement behaviors related to communication. There were four individuals included on this list for whom communication assessments were submitted (Individual #94, Individual #222, Individual #143, and Individual #491). Three of these reported that there was a PBSP, but did not address any association between communication and the target behaviors or the communication-related replacement behaviors. The assessment for Individual #222 stated that he did not have a PBSP even though he did. There were at least 43 individuals listed with co-existing behavioral concerns and severe language deficits. There were seven of these individuals included in the sample of assessments. Again, there was no evidence that the clinicians considered any	

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		relationship between communication deficits and challenging behaviors. Further, there was no department or facility policy related to the identification of behavioral challenges and related communication deficits. Substantial compliance in this area will not be achieved by merely stating that there was a PBSP in 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 to improve and enhance communication skills, is required. It was reported that collaboration did occur with psychology and other IDT members during the ISP and ISPA meetings. This was not evident in the ISPs. Fran Harman attended the BSP Committee meetings to review assessments and BSP strategies. These were appropriate, but merely first steps toward collaboration with psychology for assessment, program development, implementation, and monitoring.	
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.	<u>Integration of Communication in the ISP</u> ISPs, ISPAs, assessments, and documentation were included in the sample records submitted. ISPs were current for 35 of 38 ISPs reviewed. Three were expired at the time of this onsite review. These were for Individual #562 (2/23/11), Individual #427 (2/15/11), and Individual #229 (11/1/10). Representation by a speech clinician was documented for only 63% of the current ISPs. The majority of the ISPs made some reference to the individual's expressive communication skills, but receptive abilities were outlined infrequently. There were limited descriptions of strategies for staff to use and, in most cases, the Communication Dictionary or other devices were referenced. In some cases, it was stated that the individual used the communication dictionary. These supports were designed for use by staff to interpret communicative behaviors unique to an individual and assist them with appropriate responses, not as an assistive system for use by the individual themselves. There was no evidence that the IDT reviewed communication plans or communication dictionaries for effectiveness or implementation. Monitoring of the plans was usually noted as an action step, though as described below, the actual monitoring conducted did not address efficacy of the communication supports in place. <u>AAC Systems</u> The majority of the individual AAC systems were intended to be functional though most were located in programming areas and were not necessarily portable or meaningful across settings. Availability of some general use devices was reported, though not well documented in the materials submitted. As described above, consistent implementation continued to be a concern and, as such, meaningful and functional use by the individual often did not occur. The majority of supports provided were limited to a Communication	Noncompliance

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		Dictionary. The self-assessment identified the each of these supports as speech services, however, as described below, this review was limited to a statement that the support was available and in working condition, rather than a professional assessment of the consistency of implementation and the efficacy of the support in meeting the needs of the individual. <u>Staff Training</u> According to the schedule for NEO submitted, there was only a one hour time period available for alternate communication, which was woefully inadequate to establish staff competency in this area. The curriculum materials submitted were very limited in content and were insufficient to provide adequate competency-based training for staff to implement communication supports in a functional and meaningful manner. Inservice training was provided by the SLPs upon the introduction of a new communication system and return demonstration of implementation was required. The general training was lacking and provided little foundation upon which to build competency with regard to more specialized or individualized systems. Staff training related to communication was not included as an aspect of annual retraining. While the interactions of staff with the individuals 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.	
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	<u>Monitoring System</u> The monitoring system consisted of periodic PNMP monitoring that included communication. These were generally conducted by the PNMPCs to check for availability, condition, working order, and staff implementation of AAC devices and communication dictionaries. There did not appear to be a specific schedule for how often communication supports were monitored. By report, this was to occur at least weekly, but it was not occurring consistently. Of the 22 individuals included in the sample, completed monitoring sheets were submitted for 21 individuals (none were provided for Individual #229). Generally the sheets indicated 100% compliance across all indicators. In a few cases, it was reported that the communication dictionary was not readily located. On 3/21/12, the dictionary for Individual #151 was dated 10/27/10. Two days later the clinician documented that	Noncompliance

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	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.	this had been replaced. While this was completed in a timely manner, this had gone unnoticed for 17 months. The Dictionary submitted for Individual #151 indicated that it had been reviewed on 11/27/11. These monitoring sheets were very generic and, as such, did not provide significant information about actual implementation. For example, most did not identify the communication activity being monitored or if there was an AAC or dictionary provided. This monitoring appeared to be more of a required task, rather than a system that yielded key information about the implementation of communication programs. Additionally, there was a system in which the speech clinicians established an activity plan via the ISP. This activity plan provided very general instructions such as "assist Individual #38 in pressing the appropriate device/message throughout the day." The therapist was to monitor the activity plan on a quarterly basis. This appeared to be done inconsistently in a number of cases (e.g., Individual #84, Individual #281, Individual #407, Individual #29, Individual #304, Individual #38, Individual #72, Individual #16, Individual #328, Individual #197, Individual #196). Further it was noted that, although these reviews were conducted by speech clinicians, there was no evidence that implementation or effectiveness monitoring was conducted. In some cases, a notation stated that the activity plan was monitored and determined to be in working order and in good condition (e.g., Individual #293, Individual #311, Individual #196). The plan was to continue as written, though there was no report as to whether it continued to be appropriate or effective. In other cases, the notation related to communication dictionaries stated merely that monitoring had been conducted for condition, usage, and effectiveness, but findings of that monitoring were not documented (Individual #492). Individual #38 had been provided a CD/radio/tape player with a switch and the activity plan was implemented on 10/31/11. When the monitoring was conducted three months later on 1/29/12, the licensed clinician merely stated that these items were available and in working order, and that the plan should continue as written. There was no discussion of how often it was used and whether it was appropriate or effective. Individual #38 also had been provided three Big Talk devices. The clinician documented on 1/29/12 that each of these was in working order, but that an assessment was indicated to determine if the use of a Go Talk 4 could replace these three devices. There was no evidence of assessment documented on the Activity Plan since that time. Licensed clinicians should conduct routine reviews of the efficacy of the communication supports provided and observe and validate consistent implementation. Monitoring of communication programs and systems should be based on level of needs related to	

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		communication, though increased monitoring for an individual with changes in risk level would likely warrant monitoring across all areas to assess the impact of health status on functional performance. Communication supports were generally reviewed on an annual basis prior to the ISP. Frequency of monitoring in the interim was not identified in the assessment. On the other hand, others were identified as verbal, using words, phrases and sentences (e.g., Individual #341, Individual #169, Individual #562). They were scheduled for subsequent assessments in one year. There was no rationale for any of these plans as outlined in the assessments. Still others (e.g., Individual #224, Individual #66) were identified in their assessments to "prevent behavioral episodes through communication," yet they were not to receive a subsequent communication assessment for five years. Individual #224's BSP addressed inappropriate sexual behavior, refusal to follow instructions, and unauthorized departures. The speech clinician, however, did not discuss the relationship of these behaviors and the effectiveness of his communication abilities. Recommendations included to repeat questions, use clearly defined task expectations in a short, concise manner using simple and familiar vocabulary, and to allow for adequate time for response and to check for understanding of instructions and directives. These findings were duplicated in the ISP but it was not clear that the recommended strategies were integrated into his BSP and educational programming.	

Recommendations:

1. 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 (R1).

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

3. Develop strategies to address deficiencies in the analysis aspect of the communication assessments such as guiding questions for content in this section of the report (R2).

4. Communication strategies and communication dictionaries appeared to be considered the extent of communication supports, in some cases. While these were often excellent, they generally were a reflection of the individual's current abilities rather than methods to expand skill. Skills training for individuals was a clear need (R2-R3).

5. Current communication abilities, staff strategies, objectives to expand existing skills and a discussion of the effectiveness of communication supports should be addressed consistently in the individual ISPs (R3).

6. Communication plans and staff training is indicated to ensure appropriate and consistent implementation of recommended AAC systems (R3).

7. It is vital that there be a greater collaboration between psychology and speech clinicians throughout assessment, program development, training and monitoring aspects of supports and services (R2).

8. Consider revision of current staff training materials to address how to be an effective communication partner. The time allotted for staff training was limited and should be increased in this area. Additionally, a segment for annual re-training should be considered as well (R3).

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Individual Support Plans (ISPs) for: • Individual #453, Individual #365, Individual #219, Individual #248, Individual #350, Individual #152, Individual #401, Individual #497, Individual #583, Individual #226, Individual #572, Individual #239, Individual #423, Individual #95, Individual #375, Individual #447, Individual #557, Individual #439, Individual #183, Individual #385 o Specific Program Objectives (SPOs) for: • Individual #453 Individual #365, Individual #219, Individual #248, Individual #350, Individual #152, Individual #401, Individual #497, Individual #583, Individual #226 o Six months of master teacher data and progress notes for: • Individual #53, Individual #117, Individual #329, Individual #267, Individual #157, Individual #264, Individual #557, Individual #420, Individual #57, Individual #388 o Desensitization Plan for: • Individual #196 o A list of individuals with dental desensitization plans written in the last six months, undated o SPO treatment integrity forms, dated 11/12 o Integrity check data for 11/11, 12/11,1/12, and 2/12 o Section S Self-Assessment, dated 2/21/12 o Section S Action Plans, dated 3/15/12 o MSSLC provision action information, dated 3/12/12 o Master Teacher, performance improvement team meeting minutes, dated 3/28/12 o Section S Presentation book, dated 3/15/12 o Personal focus assessment for: • Individual #204, Individual #57 o Skill acquisition checklist, dated 6/11 o Graph of Community Training Data Cards versus Trip sheets, for 10/11 o A list of all instances of skill training provided in the community, dated 2/27/12 o Summary of community outings per residence/home for the past six months o A list of individuals employed on and off campus o Graph of engagement per home for 10/11, 11/11, 12/11, 1/12, and 2/12 o List of individuals who were under age 22 and their school assignment o MISD classroom roster, 2011/2012 o IEP, IEP progress notes, MSSLC SPOs, and ISPs for • Individual #367, Individual #320, Individual #113 o Active record of Individual #287

	o MSSLC ISP quarterly review instructions, form QSM-25 Interviews and Meetings Held: o Don Morton, Assistant Director of Programs o Kim Williams, Acting Director of Education /Training o Joann Cooper, Active Treatment Coordinator o Norvell Starling, MSSLC liaison to MISD Observations Conducted: 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 and building space on the MSSLC campus
	Facility Self-Assessment: MSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document, separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the self-assessment included relevant activities in the "activities engaged in" sections. It should include, however, activities that are in line with what the monitoring team assesses as indicated in this report. For example, for S3b, the self-assessment reported that the facility: 1. Conducted and analyzed Section S3 Settlement Agreement monitoring 2. Conducted and analyzed engagement monitoring 3. Collected and analyzed community-based training data 4. Conducted and analyzed Specific Program Objective integrity monitoring The facility rated that 95% of these items met the provision (number 1). The self-monitoring tools, however, did not weigh items and, therefore, it was not clear what 95% compliance really meant.

	Additionally, engagement (number 2) is covered in S1 and treatment integrity (number 4) is addressed in S3a. As the report below indicates, the critical items for S3b (and therefore the items that should be reviewed for the self-assessment) are: • Skill acquisition plans (SPOs) are occurring in the community • There are ongoing community activities • Attempts are made to increase number of employment positions held by individuals in the community To take this process forward, the monitoring team recommends that the facility review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the department to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the psychology department and believes that the facility was proceeding in the right direction. This was a good first step. MSSLC's self-assessment 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 self-assessment 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: • The training sheets for Specific Program Objectives (SPOs) have been revised

	• An integrity tool has been developed to assess if SPOs were implemented as written • New tracking methodology for training activities in the community had been developed • Continued support for individuals' who were entitled to educational services and coordination with the local independent school district. The monitoring team suggest that the facility focus on the following over the next six months: • 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 • Track SPO integrity measures, identify target levels of integrity, and insure the achievement of those levels.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at MSSLC. There had been consistent improvements, however, more work needs to be done to achieve substantial compliance. <u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) 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 55 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 Individual Support Plan (ISP), 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. Ten individuals SPOs were reviewed to determine if they appeared to be functional and practical. The SPO training instructions sheet had been modified to include the justification for training and individual preferences. These rationales, however, were identical for each individual reviewed, and therefore none of the SPOs appeared practical and functional for each individual, based on the stated rationale. For example: • Individual #453 had five SPOs and a general training sheet whose rationale stated, "The following SPO was developed for (Individual #453) based on his	Noncompliance

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		functional skills assessment, vocational assessment and MSSLC's advanced work behaviors assessment. Individual #453 and the PSP team developed his SPO based on his preferences and needs in the areas of job seeking skills, money skills, money skills reading/writing skills, time management skills and functional workplace behaviors social skills which were prioritized for the following training objectives and goals to better prepare him for community placement." This rationale stated that Individual #453's SPOs were based on his needs and preferences, however, because it was generic and not individualized, it was not clear from this rationale that his SPOs were practical and functional for him. It is recommended that a rationale be developed for each individual's SPO, and that the justification/rationale be specific enough for the reader to determine if the SPO was practical and functional for that individual. Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology This represented an area where the facility has made improvements since the last review. MSSLC has modified the SPO training sheet to ensure that it contained all of the above components. The new format SPO training sheets did not, however, consistently reflect the processes of maintenance and generalization. A maintenance plan ensures that the newly acquired behavior occurs following the end of formal training, while a generalization plan ensures that the behavior occurs in all the appropriate situations and circumstances outside of the specific training situation.	

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		All of the SPO training sheets reviewed contained the generic statement "Carryover training will be provided whenever skills are used on the home and/or other settings. Maintenance of an objective at or above criteria for two consecutive months will be considered mastery of an objective." The first sentence of this statement captures the essence of generalization as defined above, however, it does not specifically identify the activities that will represent generalization. For example, the generalization plan for an individual with a SPO of independently purchasing items from a vending machine could be "The individual will be encouraged to generalize these skills to the purchase of snacks in the canteen and the purchase of desired objects in the community." An example of a maintenance plan for this same individual and SPO could be "After mastering the use of the vending machine and the termination of the SPO, he will continue to make purchases in order to maintain this skill." It is recommended that all SPOs contain individualized generalization and maintenance plans that are consistent with the above definitions. 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 the range of training methodologies. <u>Desensitization skill acquisition</u> Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures were developed by the psychology department. A list of dental desensitization plans developed indicated that one plan was developed since the last onsite review. It is recommended that the psychology department develop an assessment procedure to determine if refusals to participate in dental exams are primarily due to general noncompliance, or due to fear of dental procedures. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) would then be developed. It is also recommended that individualized compliance and dental desensitization plans be incorporated into the new SPO format. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be reviewed in more detail in future site visits.	

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		Replacement/Alternative behaviors from PBSPs as skill acquisition 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. The facility recently began to include replacement/alternative behavior training in the SPO methodology. It is recommended that when replacement behaviors require the acquisition of a new behavior that replacement/alternative behavior training procedures be incorporated into the facility's general training objective methodology. Communication and language skill acquisition SPOs for only one (Individual #248) of the 10 individuals reviewed (10%) had skill acquisition programs targeting the enhancement or establishment of communication and language skills. This represented a decrease in the number of communication SPOs at the facility from the last review when 27% of the SPOs reviewed had skill acquisition programs targeting the enhancement or establishment of communication and language skills. It is recommended that the facility expand the number of communication SPOs for individuals with communication needs. Service objective programming 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 QDDPs. The monitoring team did not review these plans in this provision of the Settlement Agreement because these were not skill acquisition plans (see section F for a review and discussion of service objectives). Engagement in Activities 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. As described in past reports, engagement of individuals 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 home and day program is listed in the table below. As reported in the last review, the monitoring team was encouraged by the overall	

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		quantity of age appropriate and typical activities at MSSLC. Consequently, in several homes visited, many of the individuals were out of the homes, engaging in activities on campus and 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 63%, a slight decrease compared to that observed during the last review (i.e., 66%). An engagement level of 75% is a typical target in a facility like MSSLC, indicating that the engagement of the individuals at MSSLC continued to have room to improve. The facility's engagement data indicated a higher percentage of than the monitoring team's data. In February 2012, for example, the facility reported an average engagement score of 78%. The facility and monitoring teams data, however, reflected similar patterns of wide variation in engagement both across homes, and across measures within the same home. For example, average engagement in Barnett in December 2011 was reported to be 53%, while it was 91% in February 2012. It is recommended that the facility review these trends in their engagement data, establish acceptable levels of engagement in each home, and attempt to better understand the variables that affect individual engagement. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
M1 and M2	4/13	4:13
M5	0/5	2:5
M7 and M8	5/5	3:5
M7 and M8	2/6	2:6
M4	4/9	4:9
M4	5/9	4:9
W3	4/6	2:6
W3	2/3	1:3
B1	4/5	2:5
B1	4/7	2:7
S1	5/6	2:6
S1	6/7	2:7
L1	8/8	4:8
W8	1/1	1:1
Step Center Classroom	3 /8	3:8

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Step Center Classroom	4/5	2:5
Step Center Classroom	1/3	2:3
Vocational Workshop	21/26	6:26

Educational Services

The monitoring team again reviewed the ISD services provided to individuals at MSSLC who were entitled to educational services. A total of 77 students were receiving educational services from Mexia Independent School District (MISD). Of these, the majority attended school at the ISD's special education building (52 individuals), at the regular high school (2 individuals), or at the regular junior high school (3 individuals). Only 20 individuals were on campus at MSSLC (17 in the classrooms, 1 in his home on Longhorn, and 2 as part of the senior class vocational training program). At the time of previous reviews, there were 18 and 36 individuals at the MSSLC campus, 47 and 27 at the special education building, 4 and 11 at the high school, and none at the junior high school, respectively.

MSSLC and MISD continued to have a good and collaborative working relationship. ARD/IEP objectives were included in the MSSLC annual ISPs, information about MSSLC activities were included in MISD ARD/IEPs, and MSSLC staff attended ARD/IEP meetings (e.g., psychologist, QDDP, Mr. Starling). MSSLC implemented IEP-type SPO objectives, especially during school holidays and vacations. There were examples of the MSSLC psychologists and MISD behavior specialists collaborating on the development and implementation of behavior support plan interventions.

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. For example, the SPO for Individual #287 specifically noted that the SPO was related to his ARD/IEP. Some of the SPO activities were academic-related tasks, too.

Further, the QDDP guidelines for conducting ISP quarterly reviews required that the MISD progress report and status be included in the quarterly review. This appeared to being done regularly. For example, in the ISP quarterly reviews for Individual #287, the quarterly meeting had documentation on his MISD activities and progress. Moreover, the QDDP included a comment about Individual #287's MISD activities in the monthly ISP report that she completed.

The monitoring team does not have any further recommendations for MSSLC regarding the educational services component of this provision item.

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S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	MSSLC conducted annual assessments of preference, strengths, skills, and needs. As discussed in S1, the facility was beginning to make improvements in the documentation of how this information impacted the selection of specific program objectives. Overall, however, more work is needed to achieve substantial compliance for this item. At the time of the onsite review, the facility was using the Functional Skills Assessment (FSA) in place of 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 (also see comments regarding the FSA in sections F and T of this report). Finally, while the ISP attempted to identify individual preferences, no evidence of systematic (i.e., experimental) preference and reinforcement assessments (when potent reinforcers or preferences are not apparent) was found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	Noncompliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services 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 demonstration that SPOs are implemented as written 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. Ten quarterly reviews representing the outcome data of 44 SPOs were reviewed to determine compliance with this provision item. Twenty of those reviews (45%) indicated SPO progress or the achievement of sustained high levels (i.e., above 90%) of SPO performance. Additionally, as found in the last review, there was evidence of data based decisions concerning the continuation (e.g., Individual #388's single digit subtraction), modification (Individual #53's SPO of purchasing items from the canteen/vending machine) or discontinuation (e.g., Individual 420's SPO of using a tape	Noncompliance

#	Provision	Assessment of Status	Compliance
		measure) of SPOs. As during the last review, the implementation of SPOs was observed by the monitoring team 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 (e.g., Individual #562's SPO of community travel signs), 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. This was another area where MSSLC had made improvements since the last review. The facility began to collect SPO treatment integrity data. Treatment integrity consisted of a direct observation of staff conducting SPOs and one of the questions included "Is the SPO being implemented as written?" The monitoring team was encouraged by the initiation of the collection of treatment integrity data. It is recommended that that a schedule of SPO treatment integrity assessments be established, treatment integrity recorded and graphed, acceptable levels of treatment integrity determined, and performance feedback given to staff to ensure that goal levels of treatment integrity are achieved.	
	(b) Include to the degree practicable training opportunities in community settings.	MSSLC improved the collection of data regarding training of SPOs in the community. Data presented to the monitoring team indicated that the majority of individuals at the facility participated in various recreational activities in the community, and were provided training opportunities in the community. In order to achieve substantial compliance with this provision item, the facility now needs to establish acceptable levels of community and training activities in the community, and demonstrate the that those levels are consistently achieved. The facility began a new tracking of training of SPO objectives in the community prior to the onsite review. The documentation revealed that, from September 2011 to January 2012, the percentage of individuals who were given at least one opportunity per month to implement a SPO objective in the community ranged from 64% to 85%. Additionally, data provided the monitoring team indicated that the percentage of individuals participating in community activities ranged from 34% to 100% of individuals per month. It is recommended that the facility now establish acceptable percentages of individuals participating in community activities and training on SPO objectives, and demonstrate that these levels are achieved. At the time of the review, 20 individuals at MSSLC worked in the community. This was the same number of individuals working in the community during the last onsite review.	Noncompliance

Recommendations:

1. Ensure that the rationale for the selection of each individual's SPO is specific enough for the reader to determine if the SPO was practical and functional for that individual (S1).

2. It is recommended that all SPOs contain individualized generalization and maintenance plans that are consistent with the above definitions (S1).

3. It is recommended that the facility expand their training methodologies (S1).

4. The psychology department should develop an assessment procedure to determine if refusals to participate in dental procedures are primarily due to general noncompliance, or due to fear of dental procedures. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) should then be developed. Additionally, those individualized compliance and dental desensitization plans should be incorporated into the new format (S1).

5. It is recommended that the facility continue to incorporate alternative/replacement behaviors that require the acquisition of a new skill into SPOs (S1).

6. It is recommended that the facility expand the number of communication SPOs for individuals with communication needs (S1).

7. It is recommended that a schedule of SPO treatment integrity assessments be established, treatment integrity recorded and graphed, acceptable levels of treatment integrity determined, and performance feedback given to staff to ensure that goal levels of treatment integrity are achieved (S1).

8. The facility should establish acceptable percentages of individuals participating in community activities and training on SPO objectives, and demonstrate that these levels are achieved (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, attachments, January 2012 o MSSLC facility-specific policies: Most Integrated Setting and the Community Living Process, 1/31/11, Admissions, 9/1/11, Placement Team Review, 9/15/11, and Placement Review and Appeals, 9/15/11 o Organizational chart, 3/9/12 o MSSLC policy lists, March 2012 o List of typical meetings that occurred at MSSLC, undated o MSSLC Self-Assessment, 2/21/12 o MSSLC Action Plans, 3/15/12 o MSSLC Provision Actions Information, 3/12/12 o MSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/26/12 o Community Placement Report, last six months, through 3/1/12 o List of individuals who were placed since last onsite review (17 individuals) o List of individuals who were referred for placement since the last review (21 individuals) o List of individuals who were referred and placed since the last review (0 individuals) o List of total active referrals (42 individuals) o List of individuals who requested placement, but weren't referred (157 individuals) • Documentation of activities taken for those who did not have an LAR (0 of 148 individuals) • Special IDT, ISPA report, and notes from the PMM regarding the appeal of IDT decision to not refer Individual #152 • List of individuals who requested placement, but weren't referred solely due to LAR preference (9 individual) o List of rescinded referrals (7 individuals) • ISPA notes regarding each rescinding o List of individuals returned to facility after community placement and related ISPA documentation (1 individual) o List of individuals who experienced serious placement problems, such as being jailed, psychiatrically hospitalized, and/or moved to a different home or to a different provider at some point after placement (no information provided) o List of individuals who died after moving from the facility to the community since 7/1/09 (9 individuals, 1 since the last onsite review)

	o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (3 individual) o APC weekly reports, four, 2/10/12 through 3/1/12 • Statewide weekly enrollment report • Detailed referral and placement report for senior management (none) o Various graphs of admissions and placement department activity, five graphs, 3/16/12 o Spreadsheet of up to three obstacles to referral/placement for 37 individuals o Variety of documents regarding • Community tours, October 2011 through February 2012 (5) • Parents newsletter article and online provider brochures (2) • Trainings for facility staff, February 2012 (5) • Initiation of admissions and placement included in NEO, February 2012 (1) • Meetings with local MRA, January 2012 (1) o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred) o Spreadsheets: • Data entry information for individuals referred, undated • Pre-selection visits, undated • Pre-move site reviews, 3/19/12 o List of individuals who had a CLDP completed since the last review (13 individuals) o List used by APC regarding submission of assessments for CLDP (<u>not</u> within the CLDP) o DADS central office written feedback on CLDPs (6 individuals) and MSSLC spreadsheet that tracked submission of CLDPs to state office, state office response, and MSSLC follow-up, 3/8/12 o Three blank section T statewide self-monitoring tools o Six completed section T statewide monitoring tools, for one of the three tools, living option discussion o Three graphs summarizing the statewide monitoring tools data o Minutes from PET meetings showing presentation of section T information to PET, three meetings, December 2011 to February 2012. o MSSLC summary of community placement obstacles, 9/1/11 to 3/5/12, for 106 individuals o State obstacles report and MSSLC addendum, October 2011 o MSSLC corrective action plan for provision item T1g, 1/31/12 o PMM tracking sheet listing post move monitoring dates due and completed 3/30/12 o Transition T4 materials for: • Individual #4, Individual #531, Individual #37 o New-style ISPs and assessments for: • (none) o Old-style ISPs and assessments for: • Individual #53, Individual #500, Individual #313, Individual #31, Individual #244

	o CLDPs for: • Individual #239, Individual #82, Individual #89, Individual #88, Individual #206, Individual #399, Individual #319, Individual #428, Individual #91, Individual #85, Individual #145, Individual #413 o Draft CLDP for: • Individual #564 o In-process CLDPs for: • Individual #340, Individual #221, Individual #270 o Pre-move site review checklists (P), post move monitoring checklists (7-, 45-, and/or 90-day reviews), and ISPA documentation of the IDT meetings that occurred after each review, conducted since last onsite review for: • Individual #358: 45, 90 • Individual #326: 45, 90 • Individual #465: P, 7, 45, 90 • Individual #481: P, 7, 45, 90 • Individual #413: P, 7, 45, 90 • Individual #145: P, 7, 45, 90 • Individual #85: P, 7, 45, 90 • Individual #91: P, 7, 45, 90 • Individual #428: P, 7, 45, 90 • Individual #319: P, 7, 45, 90 • Individual #399: P, 7, 45, 90 • Individual #206: P, 7, 45 • Individual #88: P, 7, 45 • Individual #89: P, 7 • Individual #82: P, 7 • Individual #558: P, 7 • Individual #239: P <u>Interviews and Meetings Held</u>: o Sarah Ham, Jeanette Reaves, Pamela Gonner, Dana Cotton, placement specialists and admissions placement staff o Diann Thomas, DADS state office community placement staff o Carol Mays, area director, and other community day residential staff at Ruth Marie's Country Homes day program and group home <u>Observations Conducted</u>: o CLDP Meeting for: • Individual #564 o ISP Meeting for: • Individual #415

	o Self-advocacy meeting, 3/27/12 o Community group home and day program visit for: • Individual #239
	Facility Self-Assessment MSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. During the week of the onsite review, the monitoring team engaged in lots of discussion with facility staff regarding the new self-assessment. Facility staff appeared interested and eager to implement this new process correctly and in a way that would be beneficial to them. The most difficult aspect of this appeared to be understanding the somewhat subtle difference between assessing whether substantial compliance was met versus engaging in activities to meet substantial compliance. Overall, the APC included relevant activities in the "activities engaged in" sections. The activities, however, need to: • Be more comprehensive. The APC tended to rely primarily on the statewide self-monitoring tools and/or her list of action plans. The tools can be one of the activities used to self-assess, but will not likely be sufficient for most provision items and the action plans may not always address everything that needs to be addressed. • Not self-rate substantial compliance solely on a score of over 70% on the statewide self-monitoring tools. • Be described in detail so that the reader can understand what it is that the APC did. • Line up with what the monitoring team assesses as indicated in this report. The monitoring team looks at many things during its assessment of each provision item. Thus, the monitoring team recommends that the APC review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. • Identify the samples chosen. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the APC and wants believes that the facility was proceeding in the right direction. This was a good first step.

	The facility self-rated itself as being in substantial compliance with eight provision items: T1b2, T1c1, T1c2, T1c3, T1d, T1h, T2, and T4. The monitoring team agreed with five of these (T1c2, T1c3, T1d, T1h, and T2a). In addition, the monitoring team rated T2b as being in substantial compliance.
	Summary of Monitor's Assessment MSSLC continued to make progress towards substantial compliance. The specific numbers of individuals who were placed and who were in the referral and placement process remained relatively stable and appeared to be manageable. The number of individuals placed was at an annual rate of almost 9%. Approximately 11% of the individuals at the facility were on the active referral list. 17 individuals had been placed in the community since the last onsite review. 21 individuals were referred for placement since the last review. The total number of individuals on the active referral list was 42. The admissions and placement department staff made some graphs, but these were not of the data recommended by the monitoring team and were not done in a way that showed any trending. Explicitly identifying the determinations of professionals that community placement is appropriate is required by this provision. A new-style ISP meeting and a new-style ISP document were created to address this (and other topics relevant to sections T and F), however, this had not yet been initiated at MSSLC. Therefore, the facility's status in regard to this requirement remained about the same as during the previous review. No special actions were taken after an individual was referred to ensure that training objectives were considered and developed based upon the individual's referral to the community. MSSLC was engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs. A set of activities were recently agreed upon by the Monitors, DADS, and DOJ. These are detailed in the report with a statement regarding MSSLC's status for each. The bulleted lists can be used for the facility's next revision of its self-assessment. The system of tours of community providers, in particular, needed attention from the APC. Twelve CLDPs were reviewed by the monitoring team. Initiation and development of the CLDP from the time of referral was a relatively new process at MSSLC and had not progressed much since the last onsite review. IDT members continued to be very involved in the placement activities of individuals. The monitoring team was impressed with the active role IDT members took in discussions during the CLDP meetings. Further, MSSLC ensured that at least one professional staff from the IDT visited and saw the home and day program for each individual at some point prior to his or her move. One CLDP meeting was observed by the monitoring team. Overall, there was good discussion and good

	participation from attendees from MSSLC and from the community provider. The transition specialist should work on improving two aspects of the meeting. One is to include the direct care staff member more in the discussion and the other is to facilitate the meeting in a smoother manner. MSSLC made further improvements in the way it conducted and managed assessments in preparation for each individual's CLDP meeting and transition and thereby maintained substantial compliance with this provision item. Very little detail, however, was provided regarding provider training and collaboration between MSSLC clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists). MSSLC made progress in identifying essential and nonessential (ENE) supports. Essential supports that were identified were in place on the day of the move. More work, however, needs to be done regarding the identification of the full set of ENE supports for each individual. This should be a priority area given the importance of this activity and the continued need for improvement. A number of important supports and services, based on the individual's preferences, safety needs, and personal development needs were not included, evidence to show the provider's implementation of the ENE support needed improvement, and skills for the individuals to learn were noticeably absent. There was no organized QA process as required by this provision. Activities at the facility and state levels demonstrated some progress at the state level and facility level towards substantial compliance related to the identification and addressing of obstacles to referral and placement. Post move monitoring had improved at MSSLC, resulting in a rating of substantial compliance. 38 post move monitorings for 16 individuals were completed. This was 100% of the post move monitoring that was required to be completed. All 38 (100%) occurred within the required timelines and were reported in the proper format. A number of recommendations for additional improvement are provided in the report. Observation of a post move monitoring also demonstrated improvement since the last review. T4 discharge summaries were not adequately or thoroughly completed.

#	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	MSSLC continued to make progress towards substantial compliance with the items of this provision. The amount of progress, however, was hampered by the absence of the Admissions and Placement Coordinator (APC), who was on leave during the week of the onsite review as well as for a number of weeks prior to the onsite review, and by the delay in implementation of the state's new-style ISP process at MSSLC.	Noncompliance

	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.	Even so, the post move monitors (PMM) and transition specialists managed all department activities, individuals continued to be referred and placed, and post move monitoring continued to occur. The specific numbers of individuals who were placed and who were in the referral and placement process remained relatively stable and appeared to be manageable. The number of individuals placed was at an annual rate of almost 9%. Approximately 11% of the individuals at the facility were on the active referral list. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 17 individuals had been placed in the community since the last onsite review. This compared with 25 individuals, 23 individuals, and 63 individuals who had been placed at the time of prior reviews. o This number was the smallest since monitoring began, however, it was not clear if this was a trend. Therefore, data will be assessed again at the next review. MSSLC staff continued to be thoughtful about each placement. • 21 individuals were referred for placement since the last review. This compared with 27, 18, and 44 individuals who had been referred at the time of the last reviews. o This was a relatively stable number and indicated continued referrals by the IDTs. o Of these 21, 0 individuals were both referred and placed since the last onsite review. • The total number of individuals on the active referral list was 42 at the time of this review. It was 49 and 73 at the time of the previous reviews. o 19 of the individuals lived on the Whiterock unit, 5 lived on Longhorn, 5 lived on Shamrock, 5 lived on Barnett, and 8 lived on Martin. o 26 of the 42 individuals were referred for more than 180 days ▪ 5 of the 26 were referred more than one year ago. o Individuals came off of the referral list either via placement or via the rescinding of the referral. • 157 individuals were described as having requested placement, but were not referred. This compared with 160, 168, and 40 individuals at the time of the previous reviews. o Of these, 9 were listed as not being referred solely due to LAR preference. This compared to 67 at the time of the last review. o There was no documentation of activities taken for those who did not have an LAR (i.e., 0 of 148 individuals) ▪ Individuals who requested placement, who did not have an LAR, and who were not referred should be reviewed via the Placement Review Team or some other process.	

		▪ One individual requested a review by the facility's special IDT. At the time of this report preparation, the SIDT had found for initiation of transfer to another SSLC while at the same time beginning a CLDP in preparation for his ultimate referral and transition after he moved to the new SSLC (Individual #152). • The list of individuals not being referred solely due to LAR preference contained 9 names. o This was not an accurate count and needs to be completed correctly by the facility. This list should include all individuals, not only those individuals who themselves expressed a preference. • The referrals of 7 individuals were rescinded since the last review. This compared with 20 individuals whose referrals were rescinded at the time of the previous review. o Each individual's IDT met and an ISPA report was issued that provided information indicating that the decision to rescind was reasonable. o A special review team reviewed each of these rescinded referrals and made relevant comments. o Of the 7, 4 were rescinded due to the proposed provider's inability to provide the needed services within the current cost funding structure, 2 were rescinded due to declining health, and 1 was due to behavioral problems and the individual's change of decision (at least temporarily). o The APC should review these rescinded referrals to determine if anything could have been done differently during the referral and planning process, especially for situations, such as for the four individuals who were unable to continue transitioning due to funding. • 1 individual was returned to the facility after community placement. This compared with 0 individuals at the time of the previous review. o The individual was returned to MSSLC due to increased medical and nursing needs that the provider could no longer meet. MSSLC reported that the provider tried to make the placement work out, but the IDT determined that this was the best way to proceed. • Data for individuals who were hospitalized for psychiatric reasons, incarcerated, had ER visits or unexpected hospitalizations, transferred to other group homes or to a different provider, or who had run away from their community placements were not available. These data should be obtained, for at least a one year period after moving. • 0 individuals had died since being placed since the last review. 1 individual who was placed in 2010 died since the last review. 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 as indicated in the above bullets) was raised as a	

		serious concern in the previous <u>two</u> monitoring reports, but had not been addressed by the facility. • 3 individuals were discharged under alternate discharge procedures (see section T4 below). As recommended in previous monitoring reports, each of the above bullets should be graphed separately. The admissions and placement department staff made some graphs, but these were not of the above data and were not done in a way that showed any trending. To repeat from the previous report: 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. <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 ISP assessment process, occur during the annual ISP meeting, and be documented in the written ISP. To help meet this requirement, a new-style ISP meeting and a new-style ISP document were created. Training and initiation of these, however, had not yet occurred at MSSLC. Therefore, the facility's status in regard to this requirement remained about the same as during the previous review. That is, the ISP document did not specifically include any statements regarding professionals' determinations regarding most integrated settings and community placement. There continued, however, to be a statement at the end of the ISP narrative, but it did not reference the opinions of the IDT members. Further, of the annual ISP assessments attached to the ISPs given to the monitoring team to review, only the nursing assessments contained a statement of the professional's opinion. The APC should update her self-assessment tools for this provision item after the new-style ISP process and documentation requirements are brought to, and implemented at, MSSLC. <u>Preferences of individuals</u> The preferences of individuals continued to be sought and met by MSSLC IDT members. Practices continued, as were detailed in the previous monitoring report, such as individualizing the search for appropriate providers.	

		MSSLC made additional progress by ensuring that IDT members visited homes and day programs that were being considered for each individual who was referred prior to placement. <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 statewide weekly enrollment report. As recommended in previous monitoring reports, a more detailed report and periodic (e.g., weekly, monthly) verbal presentation to senior management should be done, keeping them updated on the details about individuals who are in the referral and placement process. MSSLC had taken some steps in this direction by including referral information in the monthly PIT meetings (see section E) and by having an admissions and placement staff member attend the morning clinical meetings (see section G). Even so, senior management (e.g., executive committee, QAQI Council) needed to be better informed about referral and placement activities.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. The state policy regarding most integrated setting practices was numbered 018.1, dated 3/31/10. A revision was being developed over the past months and was expected to be disseminated soon. Part of the reason for the delay may have been due to changes that were occurring to the ISP process. The admissions and placement staff reported that the facility followed the state's policy. MSSLC had facility-specific policies related to admissions and placement. None were new since the last onsite review. These facility-specific policies were Most Integrated Setting and Community Living, 1/31/11; Placement Reviews and Appeals, 9/15/11; Placement Review Team, 9/15/11; Special IDT, 8/30/11; and Admissions, 9/1/11. Implementation of the new state policy will require updating of facility policies to make them in line with the new state policy.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety	A new-style ISP was designed to address the many items that were required by the Settlement Agreement, ICFMR regulations, and DADS central office. Further, the new ISP included items that had been missing from previous ISP formats, such as professional's opinions (T1a), and the identification of protections, services, and supports (T1b1), and the identification of individual obstacles (T1b1). This new-style format had not yet been	Noncompliance

	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.	initiated at MSSLC. <u>Protections, Services, and Supports</u> Given that this major process change was soon to be underway regarding both the ISP meeting and the ISP document, the monitoring team reviewed the five old-style ISP documents that were presented by the facility and attended ISP meetings during the onsite review. Because the ISP will be changing, recommendations (other than to implement the new ISP process) are not presented here. Below, however, are two comments. • Many activities and items identified in the PFA and summarized in the very beginning of the ISP document were not included as service objectives or training objectives in the ISP. • Information from the FSA only appeared to be used in one of the five ISPs (Individual #244). Additional comments regarding the facility's current set of ISPs are provided in many other sections of this monitoring report, particularly in sections F and S. The 12 CLDPs reviewed by the monitoring team indicated that no special actions were taken after an individual was referred to ensure that training objectives were considered and developed based upon the individual's referral to the community. The monitoring team recommends that, upon referral, the APC seek out the IDT, director of education and training, and the master teacher to talk about what training objectives might be considered now that the individual was referred for placement. <u>Obstacles to Movement</u> This aspect of this provision item (the identification and addressing of obstacles for each individual) continued to be inadequately addressed at MSSLC. In the five ISPs reviewed, the IDT listed one or more obstacles, but some were not necessarily obstacles to referral or to placement. Again, the new-style ISP process will help the IDTs identify obstacles and plan strategies to potentially overcome them in a way that will move towards substantial compliance. A spreadsheet was given to the monitoring team that listed one or more obstacles for 37 individuals. It appeared to be the beginning of a project that was initiated by the APC because most of it was blank. The monitoring team was later informed that it was part of an action plan to obtain data for the annual obstacle report. The APC should also see section F1e of this report for additional information relevant to this provision item.	

	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, DADS central office, and DOJ recently agreed on the specific criteria for this provision item. The monitoring team expects that DADS will soon provide more specific direction to the APC and the facility regarding the expectations for achieving substantial compliance. MSSLC was engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs. Below are the agreed-upon activities (the closed and open bullets) followed by MSSLC's status for each. The bulleted lists can be used for the facility's next revision of its self-assessment. <u>Individualized plan</u> • There is an individualized plan for each individual (e.g., in the annual ISP) that is o Measurable, and provides for the team's follow-up to determine the individual's reaction to the activities offered o Includes the individual's LAR and family, as appropriate o Indicates if the previous year's individualized plan was completed. <u>MSSLC status</u>: MSSLC continued to follow the old-style ISP format, which did not address all three of the bullets listed immediately above. Some ISPs described what the individual had done, whereas others described what the individual might do during the upcoming year. The new ISP format will provide more guidance to the IDT and QDDP in addressing the education of each individual and LAR, however, the QDDPs will need to ensure that they address each of the three bullets listed immediately above. <u>Provider fair</u> • Outcomes/measures are determined and data collected, including o Attendance (individuals, families, staff, providers) o Satisfaction and recommendations from all participants • Effects are evaluated and changes made for future fairs <u>MSSLC status</u>: The annual provider fair was held in June 2011 and comments from the previous report are not repeated here. The monitoring team was not provided with any information regarding the next upcoming provider fair and what, if any, changes and/or improvements were being planned. <u>Local MRA/LA</u> • Regular SSLC meeting with local MRA/LA <u>MSSLC status</u>: The APC and the admissions and placement staff appeared to have a good working relationship with the local authority. They were supposed to meet quarterly, but apparently only one meeting had occurred in the last six months (1/6/12). More collaboration will be required, especially if MSSLC will be successful in placing individuals with more challenging medical needs.	Noncompliance

		Education about community options • Outcomes/measures are determined and data collected on: o Number of individuals, and families/LARs who agree to take new or additional actions regarding exploring community options. o Number of individuals and families/LARs who refuse to participate in the CLOIP process. • Effects are evaluated and changes made for future educational activities MSSLC status: MSSLC had not yet started to address this activity. The APC should consider summarizing the data from all of the CLOIP reviews, including the recommendations made by the MRA/LA CLOIP workers. Tours of community providers • All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). • Places chosen to visit are based on individual's specific preferences, needs, etc. • Individual's response to the tour is assessed. MSSLC status: Only five community tours had occurred since the last review and only 17 individuals participated. Tours can be a good way for individuals to see what some of their community options might be. This is especially important for the many individuals at MSSLC who are capable of participating in making decisions about their own transitions. Although the number of tours and participants was low, the staff attending completed a detailed one page report of each individual's participation and reaction to the tour. The staff reports, however, also noted that on three of the five tours (60%), the tour was delayed due to MSSLC transportation, staffing, or other organizational problems. This negatively affected some of the tours. Also, compared to the time of the previous review, there was less attention being paid to tours. For instance, the spreadsheet that tracked tour participation appeared to no longer be in use. Visit friends who live in the community MSSLC status: MSSLC was not yet implementing this activity in any organized manner, however, in one of the ISPs reviewed, the IDT talked about having the individual do this very activity (Individual #53). Education may be provided at • Self-advocacy meetings • House meetings for the individuals • Family association meetings or • Other locations as determined appropriate MSSLC status: The admissions and placement staff had made progress on this activity. Activities included an article in the parent newsletter, the creation of online	

		provider brochures, and participation in self-advocacy groups. A plan for staff to learn more about community options • management staff • clinical staff • direct support professionals MSSLC status: MSSLC made good progress on this activity. For instance, five trainings, one on each unit, were given for facility staff in February 2012, and admissions and placement staff were planning to be included in new employee orientation, though this had not yet begun as of the time of this review. Individuals and families who are reluctant have opportunities to learn about success stories • As appropriate, families/LARs who have experienced a successful transition are paired with families/LARs who are reluctant; • Newsletter articles or presentations by individuals or families happy with transition MSSLC status: The APC was not yet implementing this activity.	
	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 during the living options discussion at the annual ISP meeting, or at any other time if requested by the individual, LAR, or IDT member. In addition, a listing was given to the monitoring team showing every individual and whether the IDT referred the individual for placement to the community, to another SSLC, or to another home at MSSLC. The monitoring teams have been discussing this provision item at length with DADS and DOJ. To meet substantial compliance with this provision item, the facility will need to show that: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual assessments. o This was only being done regularly by the nursing department. • The determinations of professionals were discussed at the annual ISP meeting, including a verbal statement by each professional member of the IDT during the meeting. o This was not yet occurring at MSSLC. • Living options for the individual were thoroughly discussed during the annual ISP meeting. o This was more evident during the observed ISP meetings at MSSLC.	Noncompliance

		• Documentation in the written ISP regarding the joint recommendation of the professionals on the team regarding the most integrated setting for the individual, as well as the decision regarding referral of the entire team, including the individual and LAR o This was not yet occurring.	
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. Twelve CLDPs were reviewed by the monitoring team. This was 100% of the CLDPs submitted to the monitoring team for review. MSSLC, however, had completed a total of 13 CLDPs since the last onsite review, but one of these was not submitted to the monitoring team (for Individual #558). Of these 12, individuals were from four of the five units: Three from Martin, three from Barnett, four from Shamrock, and two from Longhorn. None were from Whiterock. Of these 12, they ranged in age from 17 to 64 years of age. Lengths of admission at MSSLC ranged from two years to 48 years. <u>Timeliness</u>: It was impossible to determine when each of the 12 CLDPs was developed. Please see the paragraph immediately below for more discussion. <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. At MSSLC, this was at a meeting called the APC-PMM-IDT meeting. This typically occurred at the ISP meeting (if a referral occurred then) or within a week or so after the referral. There was an expectation that the CLDP contents would be developed and completed over the months during which referral and placement activities occurred. This was a relatively new process at MSSLC and had not progressed much since the last onsite review. Three of these in-process CLDPs were reviewed. They contained the same minimal information whether the referral had occurred only 30 days ago or as much as 120 days ago. The admissions and placement staff noted that they were going to be working on improving this. If so, that is, if the CLDP is initiated and developed over the subsequent months, MSSLC will meet the requirement of this provision item for the timely initiation and development of the CLDP. In addition, there were some instances in which many months had passed between activities (e.g., Individual #239, Individual #89, Individual #145). This should be more explicitly explained in the 180-day monthly notes. <u>IDT member participation</u>: IDT members continued to be very involved in the placement activities of the individuals who were placed. The monitoring team was impressed with the active role IDT members took in discussions during the CLDP meetings, as	Noncompliance

		documented in the completed CLDPs (and see T1e below). Further, MSSLC made progress in ensuring that at least one professional staff from the IDT visited and saw the home and day program for each individual at some point prior to his or her move. This information was maintained on a spreadsheet with an accompanying graph regarding all types of relevant information (e.g., list of all providers and number of visits, number and type/department of staff who visited). The admissions and placement staff should continue to maintain and update this information. <u>CLDP meeting prior to move</u>: One of the admissions and placement transition specialists was responsible for leading all of the CLDP meetings prior to each individual's move. The CLDP meeting for Individual #564 was observed by the monitoring team. Overall, there was good discussion and good participation from attendees and from the provider's managers who were in attendance and on the speakerphone. The transition specialist should work on improving two aspects of the meeting. One is to include the direct care staff member more in the discussion, especially regarding relevant topics. The other is to facilitate the meeting in a smoother manner so that interesting discussion is not deadened by rote questions, such as "so who is the responsible person?" The APC and the transition specialist should work on this together. <u>Post post-move monitoring IDT meetings</u>: IDT meetings occurred after every post move monitoring visit, even if there were no problematic issues. This was an improvement from the previous review. Please also see T2a below.	
	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. Some comments regarding the actions in the CLDP are presented below. • The CLDPs identified the need for training for community provider staff. o Very little detail was provided regarding this training. The CLDPs did not include any detail regarding what should be trained, which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff). o The method of training was not indicated, such as didactic classroom, community provider staff shadowing facility staff, or showing competency in actually implementing a plan, such as a PBSP or NCP. o Training should have a competency demonstration component. This was often included. If a competency component is not required, a rationale should be provided. • The CLDP contained a somewhat standardized list of items and actions to occur on the day of the move. The content of this list was appropriate, however, it did	Noncompliance

		not identify who was responsible for these actions, and how their completion was to be monitored and ensured. • Actual implementation of ENE supports by staff should be required in the essential and nonessential support sections, not only inservicing. Some progress was seen towards this end. • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. o This was especially important for many of these individuals. • Also see comments in T1e below. • The CLDP documents were presented in an organized manner with three appendices, for assessments, individualized instructions (e.g., PBSP, PNMP, data sheets), and ISPA meetings. DADS central office conducted reviews of six of the CDLPs. The monitoring team reviewed these comments. As usual, these were comprehensive and the reviewers noted a number of problems with the CLDP, including the absence of many important supports and considerations for each individual. The monitoring team was in agreement with the reviewers' comments (and as noted in T1e below, found other considerations that were missing from the CLDP). The facility should be certain to make use of this resource. For one of the six, the IDT's response to each of the items on the list was given to the monitoring team. • As noted in previous reports, state office should consider developing a metric to determine if facilities are making progress, that is, whether the 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. This included ENE supports and other pre- and post-move activities.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The CLDPs contained evidence of individual and LAR review. Individuals and their LARs were very involved in the process. The monitoring team was impressed with this aspect of MSSLC's referral and placement program. Many examples were provided in the CLDPs reviewed by the monitoring team.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive	MSSLC made further improvements in the way it conducted and managed assessments in preparation for each individual's CLDP meeting and transition and thereby maintained substantial compliance with this provision item.	Substantial Compliance

	assessment of needs and supports within 45 days prior to the individual's leaving.	First, a meeting was held a few weeks prior to each scheduled CLDP meeting for the IDT to review the status of all assessments so that time would not be wasted during the CLDP meeting (the APC called this the pre-CLDP meeting). Second, she made sure that all assessments were either completed or updated within 45 days of the individual's actual move date. In once case, she had all of the assessments again reviewed and updated because the individual's move date had changed (Individual #82). Third, the APC kept a checklist of the required set of 13 assessments. The monitoring team recommends that, rather than a check mark, she record the actual date of the assessment update. Fourth, these assessment updates were written specifically for the individual's transition and included sections, such as "Instructions to provider" and "Recommendations in the community setting." These sections helped focus the professionals on the individuals' specialized needs in his or her upcoming new home and day settings. Each of these assessments was attached to the CLDP. In the body of the CLDP, there was also a section for a description of the IDT's review of the 13 assessments. Each of these 13 sections had two sub-sections, one described the deliberations (i.e., discussion) of the IDT regarding the assessment, and the other listed the recommendations, taken verbatim from the written assessments. It was very good to see the interesting discussions that occurred, rather than just a cut and paste of the assessment contents. In the recommendations section, however, the monitoring team recommends that the listing be what resulted from the deliberations, not a verbatim list from the attached assessment. The monitoring team understands that the recommendations were inserted prior to the CLDP meeting. That was a reasonable way to do this, however, after the meeting, these should be edited to indicate the results of the deliberations, even though, in most cases this will be no more than the verbatim list. If so, the CLDP should indicate that the list was taken verbatim from the assessment. This is recommended because, in some cases, the deliberations indicated additional recommendations (that did not get included in this recommendations section) or indicated the IDT's disagreement with some of the recommendations in the assessment (e.g., psychiatrist recommendations for Individual #85). By doing this, it is less likely that important ENE supports will be overlooked.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those	MSSLC made progress in identifying essential and nonessential (ENE) supports, however, additional improvement was still needed. Twelve CLDPs were reviewed along with their attachments, typically assessments, other relevant documents (e.g., BSPs, PNMPs, DPs), ISPA meeting notes, and ISPs. Some progress was seen in that more ENE supports were included that related to individual's overall preferences as well as the needs of the individuals, and there were ENE supports that were individualized. • Individuals had between 25 and 30 ENE supports. • There was real progress in the inclusion of individualized ENE supports. o Individual #319's list of ENE supports included ensuring he had the	Noncompliance

	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.	opportunity to go to church, that he had $2 in his wallet on Fridays, and that the provider addressed a long-standing problem of him wearing multiple shirts when its hot out in the summer. o Individual #91's list of ENE supports included seeking a drivers license and learning Spanish. • MSSLC included some standard ENE support in almost every CLDP, such as taking the individual's weight, having his or her diet reviewed, and connecting with a new PCP. Given that there were also numerous individualized ENE supports, this was acceptable and reasonable. • It was good to see that the ENE supports included some detail on what information needed to be brought to the new PCP. That being said, more work, however, needs to be done regarding the identification of the full set of ENE supports for each individual. The APC should make this a priority area given the importance of this activity and the continued need for improvement. The APC should also again review the contents of section T1e in previous MSSLC monitoring reports for more detail, examples, and direction. The lists of ENE supports still needed more work because a number of important supports and services, based on the individual's preferences, safety needs, and personal development needs were not included. The amount of items missing, however, was improved since the last onsite review. Some examples are below. • Individual #239: Her ENE supports did not mention a chopped diet and her favorite activities were only required to be offered twice per week. • Individual #89: There were no ENE supports for a backyard swing, pureed food, to be fed by staff, and to maintain family relationships (especially given that her brother was opposed to the move). • Individual #319: A number of ENE supports were missing, such as his communication dictionary, recreational activities in the community (there were so many that he liked), and attending a work/day setting that was around lots of other people. • Individual #428: There were no ENE supports regarding his sexual offending history, or regarding supporting him to continue to improve at reading. • There were no specific references to the use of positive reinforcement, incentives, and/or other motivating components to an individual's success, even though these were indicated as being important to these individuals. To help further improve the identification of important ENE supports, the monitoring team has some specific recommendations and comments: • It appeared that the IDT often limited the list of ENE supports to what was written in the set of professional assessments and assessment updates. To	

		address this, the transition specialist responsible for managing the CLDPs should, while reviewing the assessment updates and while assembling the draft CLDP in preparation for the CLDP meeting, read everything in the entire CLDP and in every assessment. Based on this, she should then create her own list of important items to bring to the CLDP meeting for possible inclusion as ENE supports. • Various members of the admissions and placement staff should engage in the same activity as in the bullet immediately above in an attempt to achieve an inter-reader agreement on the generation of ENE supports. This might also be done with the DADS central office staff who review CLDPs and/or with APCs at other facilities. Evidence to show the provider's <u>implementation</u> of the ENE support needed improvement in the lists of ENE supports. For ENEs requiring implementation, the support description needs to provide detail about what it was that was supposed to implemented, such as the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. • Any ENE support that calls for an inservice should have a corresponding ENE support for <u>implementation</u> of what was inserviced. A rationale should be provided for any ENE inservice support that does not have a corresponding ENE support for implementation. • Individual #85: His list of ENE supports contained a good example, that is, of the provider keeping a daily checklist of implementation of an activity. In this case, it was for meal preparation. • In Individual #239's CLDP, a good list of behavior problem prevention strategies was on page 2, but these were not included as an ENE support. The list of ENE supports included implementation of her BSP, but the only data required were if behavior problems occurred, not implementation of these other, very important, actions. • Interestingly, in Individual #88's CLDP, the provider refused to use the facility's Provider Observation Notes form that the admissions and placement staff gave to providers. This was a somewhat long and detailed form (not all that dissimilar from the observations notes form used at the facility, see section T2a and section V). The provider said they would use DADS' form for HCS providers. In the monitoring team's opinion, a better compromise might have been reached because it was unlikely that the DADS form would provide the post move monitor with what she needed. Skills for the individuals to learn were noticeably absent from the list of ENE supports. • Individual #89: Some good basic learning skills were included in her ISP, but none carried over to her list of ENE supports, such as looking towards someone	

		who was talking to her, making eye contact, and being on task for five seconds. • Individual #88: A very weak list of training objectives was included in his ISP and none were carried over to his ENE supports. • Individual #399: It was good to see a relevant training objective in his list of ENE supports (for cooking), however, one was not enough. His ISP had other skills, such as reading. • Individual #85: He didn't have any ENE supports related to skill training, even though his ISP had important skills training objectives, such as street crossing, turning on water, and brushing his teeth. This provision item also requires that: • Essential supports that are identified are in place on the day of the move. For each of the individuals, the pre-move site review was conducted by the PMM and one other member of the IDT (e.g., QDDP, master teacher, psychology staff, RN case manager, speech therapist). Each review indicated that each essential support was in place. • Each of the nonessential supports should have an implementation date. All of them did. • MSSLC recently began holding an IDT meeting immediately following the pre-move site review before the individual moved. This was a good addition to the transition process at MSSLC.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	MSSLC made only little progress towards implementing a quality assurance process, however, it was in the very early stages. To try to determine what it was that the department did since the last onsite review, the monitoring team looked at the APC's PET meeting presentations for December 2011, January 2012, and February 2012; three pages of graphs titled Settlement Agreement Compliance Report for 9/1/11 through 3/16/12; six completed LOD statewide self-monitoring tools; and the department's self-assessment, action plans, and actions completed. Based on this, it appeared that there was no organized QA process as required by this provision item. To create a more organized (and thereby more effective and useful) process, the APC should align her activities with the overall self-assessment that she was developing for this entire provision, section T. This means that the department will need to self-assess its performance on every provision item by collecting data, reporting data, and making changes in activities based upon these data. The APC would benefit from working closely with the QA department. Regarding the documents reviewed by the monitoring team: • The PET meeting minutes did not provide any useful information to the reader regarding what it was that the department was doing.	Noncompliance

		• The three pages of graphs seemed to be a summary of data collected for a six-month period for three different statewide self-monitoring tools, but there was no trending, the number of cases reviewed was not stated, and the items reviewed were not included. • Six completed statewide self-monitoring tools were submitted, three each for January 2012 and February 2012. It was not clear if other statewide self-monitoring tools (there were three different tools for section T) were being completed (though it seemed so because three different graphs were submitted). • The following two comments are repeated from the previous monitoring report. o At MSSLC, and perhaps across the state, there appeared to be confusion as to whether these were to assess ISP meetings, CLDP meetings, and post move monitoring by direct observation, or if they were to assess the completed ISP document, CLDP document, and post move monitoring report. This needs to be clarified. o 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.	
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,	Activities at the facility and state levels demonstrated some progress at the state level and facility level towards substantial compliance with this provision item. Some data were summarized in a table, from 9/1/11 to 3/5/12 for a total of 106 of the individuals (27% of the population). These 106 individuals were some of those who themselves requested referral, that is, these data did not include all of the individuals at MSSLC or even all of those who requested referral (see T1a). These data indicated that the obstacle to referral was due to behavioral/psychiatric problems for 44% of the sample, legal issues for 24% of the sample, and LAR preference for 26% of the sample. The APC's report of the need for community providers who can successfully support individuals with behavioral and psychiatric challenges (as well as forensic histories) was supported not only by the data table, but by the monitoring team's observation that no individuals were placed over the past six months from the Whiterock unit and, moreover, 19 of the 42 individuals on the referral list (45%) were from the Whiterock unit. Further, this data system only appeared to allow the IDT/APC was allowed to indicate one obstacle, even if more than one existed. To that end, the admissions and placement staff maintained another listing of individuals with spaces for up to three obstacles. This list was only recently begun, was not complete, and it was not clear as to how it was going to be used (see T1b1).	Noncompliance

	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.	The APC, however, planned to look at her data collection system to ensure it was following state policy (February 2012), provide training to those who collected and recorded the data (February 2012), begin to collect it correctly (March 2012), and present the data periodically to QAQI Council (June 2012). She indicated some of this in a Corrective Action Plan that was being monitored by the QA department (see section E). The narrative and data tables presented in the MSSLC addendum to the state's report provided some good information and insight into the population, challenges, and future of referrals and community placement at MSSLC. As duly noted by the APC in that addendum, more work was needed (e.g., data collection system, analyzing of data) before the facility could complete an adequate comprehensive assessment of obstacles. The facility should also consider a data system that needs to be able to separate out the difference between an obstacle to referral and an obstacle to placement. Assistance from the QA department and from state office might be helpful in analyzing data once it is collected. At the state level, DADS created a report summarizing obstacles across the state and included the facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. • The statewide report listed the 13 obstacle areas used in FY11. DADS will be improving the way it categorizes and collects (and the way it has the facilities collect) data regarding obstacles. • DADS indicated actions that it would take to overcome or reduce these obstacles o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	

T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 9/1/11 through 3/1/12. 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 IDT 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
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		

T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Post move monitoring had improved at MSSLC, resulting in a rating of substantial compliance. <u>Timeliness of Visits</u>: Since the last review, 38 post move monitorings for 16 individuals were completed. Post move monitoring occurred for these 16 individuals at 13 different providers, some as far away as Lubbock and Beaumont. This was 100% of the post move monitoring that was required to be completed. 37 of the 38 were completed by PMMs Dana Cotton and Pamela Gonner. 1 of the 38 was completed by PMM Sarah Ham. Ms. Ham's other duties included training on the MSSLC campus of numerous staff and IDTs, managing admissions and placement databases, and handling various other activities while the APC was on leave. All 38 (100%) were reviewed by the monitoring team. All 38 (100%) occurred within the required timelines. <u>Content of Review Tool</u>: All 38 (100%) post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. Post move monitoring report forms were completed correctly and thoroughly. Good information was included. PMMs conducted good follow-up, especially when a provider did not provide proper documentation; this often improved from the 7-day to the 45-day reviews. Although this provision item was rated as being in substantial compliance, additional efforts will be required by the PMMs in order to continue to improve their process and ensure better consistency across their reviews. First, below are three comments regarding good practices seen in some, but not all of the post move monitoring reports. These practices should become standard practice. • Some reports included good information as to what the PMM did under the "Evidence reviewed" column. This should become consistent across all reports. • Some reports included a couple of sentences regarding the LAR/family satisfaction with the placement (question #9) and the individual's satisfaction (question #11). This should be explicitly stated in every review. For example, for Individual #145, questions #9 and #11 were both scored as Yes, however, in the IDT review, the QDDP reported that his mother was very unhappy with the placement. This information would have been good for the PMM to have found and to have reported on within the post move monitoring report. • Within the series of additional questions, some reports had the individual's psychiatric diagnoses, psychiatric medications, and medical conditions inserted	Substantial Compliance

		right into the post move monitoring form. This was good to see and should be standard practice. In addition, the following items should be addressed. • Some comments were identical in both the 45- and 90-day reviews. The PMM should somehow indicate that status remained the same because the reader cannot quite tell if this was the current status or if the previous wording was perhaps accidentally carried forward. • There should be better post move monitoring regarding implementation of ENE supports, such as daily use of a shower chair and application of the positive aspects of behavior plans (rather than only recording when a behavior problem occurred). o The PMMs should ensure these get included in the CLDP when it is developed. • The comment "There are no concerns or recommendations" was frequently used. It was, however, insufficient, especially given the amount of time the PMM puts into doing these visits and reports. • A subjective closing statement should be included at the end of every report. To repeat from the previous monitoring report: o 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. In addition, 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 IDT (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 IDT, will enhance the quality of the post move monitoring report, and be useful to DADS, the monitoring team, and any other reviewers. Use of Best Efforts to Ensure Supports Are Implemented: IDTs, the APC, and the PMM put a lot of effort into these placements. As a result, these placements appeared to be very successful and few serious problems were reported. The PMM followed up with the IDT regarding questions she had when conducting post move monitoring. A good example were a number of questions regarding Individual #82 at his 7-day review that were discussed and documented in the ISPA following the review. The PMMs developed a somewhat standardized observation note for the residential and	

		day program sites. This was a multi-page form and was a very good idea. The PMMs, however, need to make sure the observation note template is very individualized. Items that are irrelevant should be deleted so that there are not pages and pages of blanks or not applicable notations. A document that is too lengthy and not fully used will tend to obscure the recording of important narrative information that can be useful to the PMM and to the provider. IDT meetings were held following 38 of the 38 post move monitoring visits (100%).	
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 accompanied the PMM Sarah Ham on a 45-day post move monitoring visit to the day program and home of Individual #239. The individual had moved to her new home only two weeks prior. The 7-day review had occurred, but the report was not yet completed. The PMM conducted this review, primarily so that the monitoring team could observe. Even though this visit fell within the 8-45 day requirement, she planned to conduct a second visit later in this interval, and then conduct the final visit closer to the end of the 90-day period. The PMM improved her performance since the last onsite review and, as a result, this provision item was rated as being in substantial compliance. The PMM asked many questions and looked specifically for documents and other evidence of ENE supports.	Substantial Compliance
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 reported to have been discharged under this T4 provision. Two of the individuals were found to no longer be eligible for services (T4e). For the third individual, the order placing him at MSSLC was vacated by the court (T4f). For the most part, the discharges complied with CMS-required discharge planning, except that important requirement for the facility to provide a post-discharge plan of care that will assist the individual to adjust to the new living environment was not done sufficiently for two of the three individuals. For one of the two, it consisted of a mere two lines and for the other individual, it was blank. Therefore, substantial compliance was not maintained for this provision item.	Noncompliance

Recommendations:

1. 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 (T1a).

2. Identify those individuals who would have been referred except for the preference 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 IDTs would otherwise have referred. Add this list to the Community Placement Report (T1a, T1h).

3. The APC should do a detailed review (i.e., root cause analysis) of each rescinded referral and any other post move serious incidents, such as hospitalizations, psychiatric admissions, housemate changes, or moves to different homes or apartments, to determine if anything different should be done in future transition planning to reduce the likelihood of these types of problems occurring (T1a).
    a. Review the four individuals whose referrals were rescinded due to funding.

4. Data for individuals who were hospitalized for psychiatric reasons, incarcerated, had ER visits or unexpected hospitalizations, transferred to other group homes or to a different provider, or who had run away from their community placements were not available. These data should be obtained, for at least a one year period after moving (T1a).

5. Each of the data sets listed in T1a should be graphed separately, and included in the facility's QA program (T1a, T1f).

6. Ensure that professional determinations are explicitly included in the ISP meeting, and that these professional determinations are clearly indicated in the ISP document. Professional determination is separate from both the preference of the individual, the LAR, and the opinion of the IDT as a whole (T1a, T1b1).
    a. Update self-assessment tools once the new-style ISP is in place at MSSLC.

7. The APC should complete a more detailed report and periodic (e.g., weekly, monthly) verbal presentations to senior management, keeping them updated on the details about individuals who are in the referral and placement process (T1a, T1b2).

8. Facility-specific policies will need to be revised or perhaps totally re-written once the new state policy is finalized and disseminated (T1b).

9. Upon referral, the APC should seek out the IDT, director of education and training, and the master teacher to talk about what training objectives might be considered now that the individual was referred for placement (T1b1).

10. Attend to the detail provided in T1b2. The nine bulleted lists might be used in the facility's self-assessment process (T1b2).

11. Develop/grow the CLDP from the time of referral onward (T1c).

12. More detail needs to be provided in the CLDP regarding training for provider staff (T1c1).

13. The CLDP should describe how MSSLC clinicians will collaborate with community clinicians, such as via telephone contact or face to face meetings (T1c1).

14. The list of items in the day of move activities needs to specify who was responsible for these actions, and how their completion was to be monitored and ensured (T1c1).

15. Write the date of the assessment rather than a check mark on the assessment tracking checklist (T1d).

16. In the CLDP assessments section, have the recommendations be what comes out of the CLDP meeting rather than identical to what is in the professionals' assessments (T1d).

17. Ensure that all important supports and services, based on the individual's preferences, safety needs, and personal development needs are included in the list of ENE supports (T1e).
    a. Admissions placement staff should review all of the CLDP information (not only the professional assessments) when creating the list of ENE supports.
    b. Consider having more than one person review the CLDP information to see if there is agreement across admissions and placement staff on the list of ENE supports.

18. Ensure there is an ENE support for the implementation of important supports (not only the presence of an item or the occurrence of staff training) (T1e).

19. Include skill acquisition in the list of ENE supports (T1e).

20. Develop an organized QA program for section T (T1f).

21. Conduct the comprehensive assessment of obstacles at MSSLC (T1g).

22. Improve the post move monitoring report content by addressing the other bulleted items in T2a.

23. Ensure that provider's observation notes form is individualized (T2a).

24. T4 discharge reports need to be completed thoroughly and completely (T4).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o MSSLC Section U Presentation Book o Determination of Need of Guardian/Priority Tool o MSSLC Prioritized Guardian/Advocate List o Rights Assessments for: • Individual #127, Individual #227, Individual #524, Individual #120, Individual #195, and Individual #51 o Individual Support Plans: • Individual #151, Individual #196, Individual #126, Individual #143, Individual #377, Individual #589, Individual #56, Individual #293, Individual #238, Individual #183, and Individual #373 Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Charlotte Kimmel, PhD, Director of Psychology o Valerie McGuire, QDDP Coordinator o Terri Moon, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 3/27/12 and 3/29/12 o Human Rights Committee Meeting 3/27/12 o Shamrock PIT Meeting 3/28/12 o Restraint Reduction Committee Meeting 3/28/12 o Quarterly IDT meeting for Individual #477 3/26/12 o Annual IDT meeting for Individual #41 3/28/12
	Facility Self-Assessment: MSSLC submitted its self-assessment. It was updated on 2/21/12. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment

	activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had not implemented the audit process using the tools developed by the state office to measure compliance with the Settlement Agreement. The self-assessment action taken by the HRO to address section U did not indicate that an adequate audit system was in place to self-assess compliance. The facility self-assessment commented on the overall compliance rating for each provision item, based on the sample a sample of requests for advocates or guardians. It did not describe criteria used to evaluate compliance for each item or details on specific findings. For example, for item U1, activities engaged in included Reviewed the number of requests for advocates or guardians submitted by the interdisciplinary teams. The results of the self-assessment noted: as a result, there were 16 individuals in need of an advocate and 5 in need of a guardian. The self-assessment discussed how IDTs were identifying need for a guardian or advocate, what constituted compliance, or a compliance percentage for this particular activity. The facility is moving in the right direction with the new self-assessment process. It will be important to look at the self-assessment activities in more detail and determine if the audit process is an effective way to assess compliance. Compliance self-ratings were not in agreement with compliance ratings found by the monitoring team. The facility assigned a rating of substantial compliance to provisions U1 and U2 in the narrative (though the letter N was written in the compliance column). The monitoring team did not agree that the facility was in substantial compliance with the provisions in section U. There had not been progress made towards substantial compliance.
	Summary of Monitor's Assessment: Some positive steps that the facility had continued in regards to consent and guardianship issues included: • The Human Rights Committee continued to meet and review all restrictions of rights. • The facility had a self-advocacy group comprised of individuals residing at the facility. • The Human Rights Officer continued to work with families applying for guardianship. • The Community Relations Director maintained contact with community resources for guardians and advocates. • The HRO reviewed requests for advocates or guardians submitted by the IDTs. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility had not yet developed a priority list of individuals needing an LAR, IDTs were not adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite.

	The facility had a Human Rights Committee (HRC) in place to review restrictions requested by the IDT. At the HRC meeting relevant discussion occurred, but did not adequately address important aspects of restrictions, informed consent, and LAR involvement.

#	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.	The facility did not have a prioritized list of individuals lacking both functional capacity to render a decision and an LAR. A list had been developed that included 22 individuals at the facility that had been prioritized as high need for an advocate. A sample of 12 ISPs was reviewed for evidence that the team had discussed the need for guardianship. Six (50%) individuals in the sample did not have guardians. There was evidence in all (100%) of the 12 ISPs reviewed that teams were discussing the need for guardianship, however, discussion was not based on an adequate assessment of the individuals functional capacity to render a decision regarding health or welfare. For example, • The ISP for Individual #293 noted that he did not have a guardian and did not have a need for a guardian because his aunt advocated for him. There was no documented discussion of his capacity to render informed decisions. • The ISP for Individual #56 stated that he did not have a guardian, though his father acted as an advocate on his behalf. His father did not attend his annual ISP meeting and did not submit the preplanning questionnaire prior to the meeting. His ISP noted that he was able to give informed consent in regards to programming. He stated during the meeting that he would like to live in a group home. The team overruled his request for less restrictive placement without input from his advocate. IDTs need to hold more thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. Priority for guardianship should be based on this discussion. 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,	The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. The Human Rights Officer also provided information to community agencies on advocacy opportunities at the facility. A guardian had been procured for one individual at the facility in the past six months after his IDT determined the need for guardianship. The facility did have some rights protections in place, including an independent assistant ombudsman housed at the facility, and a rights officer employed by the facility.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	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. At the HRC meeting observed by the monitoring team, relevant discussion occurred, but did not adequately address important aspects of restrictions, informed consent, and LAR involvement. • Committee members engaged in discussion regarding alternative restrictions, but did not hold adequate discussion regarding the use of appropriate programming to reduce the need for restrictions. • The HRC did not address the individual's ability to give informed consent in regards to the need for guardianship when reviewing rights assessments. • There was not adequate documentation that LARs were involved in decision making prior to approval by the HRC. QDDPs were routinely sending a letter informing the LAR (when applicable) of the rights restriction. The restriction was then approved by the facility director and the HRC without LAR input. In some cases, the HRC was not even sure if the individual had a guardian. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals.	

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR (U1).
2. Maintain a prioritized list of individuals that need a guardian (U1).
3. Document meaningful efforts to include LARs in decision making (U1)
4. Assist individuals that need guardians to obtain a guardian (U2).
5. 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 Three MSSLC recordkeeping-related policies: Recordkeeping practices Adm#6 12/1/11, Individual notebook procedure Adm#7 12/5/11, and Monitoring of individual notebooks Adm#8 12/15/11 o Organizational chart, 3/9/12 o MSSLC policy lists, March 2012 o List of typical meetings that occurred at MSSLC, undated o MSSLC Self-Assessment, 2/21/12 o MSSLC Action Plans, 3/15/12 o MSSLC Provision Actions Information, 3/12/12 o MSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/26/12 o List of all staff responsible for management of unified records o Agenda for statewide meeting of recordkeeping staff, 1/25-26/12 o Tables of contents for the active records, individual notebooks, and master records, updated 11/29/11 o List of eight other types of records/binders kept at MSSLC for various information (e.g., food intake book, active treatment activities book), March 2012 o Section V presentation materials and minutes from PET meetings, September 2011 to February 2012 o Section V quarterly review presentation document for QAQI Council, 2/23/12 o Variety of documents: emails, completed forms, meeting minutes, training documentation addressing a number of recordkeeping-related topics: • Improvement of management of individual notebooks • Security of active record rooms • Dividers in the nursing section of the active records • Staff inservice and sign-in sheets for training on individual notebook process • Improvement of filing in the active records o Samples of completed AAUD 15-item tool, and highlighted recordkeeping section of the MSSLC Active treatment monitoring and coaching guide o A spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, 3/9/12 o Email regarding state office expectations for facility-specific policies, from central office SSLC assistant commissioner, Chris Adams, 2/15/12 o Blank tools used by the URC: table of contents form, statewide self-monitoring tool, and V4 questionnaire o Blank record clerk monthly progress note tracking sheet (one page)

	o List of individuals whose unified record was audited, September 2011 through February 2012 o Completed unified record audit tools for 10 individuals, all from January 2012 o Various lists of medical consultations, March 2011 through November 2011 o Email notification of relevant staff of the results of monthly audits, September 2011 to December 2011 o Responses from HRO and Education and Training Department to the emailed results of monthly audits o Review of active records and/or individual notebooks of: • Individual #287, Individual #69, Individual #109, Individual #92, Individual #514, Individual #332, Individual #264, Individual #564, Individual #415 o Review of master records of: • Individual #34, Individual #198, Individual #60, Individual #366, Individual #569, Individual #174 <u>Interviews and Meetings Held</u>: o Elaine Schulte, Director of Client Records o Sherrie Price and Misty Samuels, Unified Records Coordinators <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area o Shared drive
	Facility Self-Assessment: MSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the director of client records (DCR) described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. During the week of the onsite review, the monitoring team engaged in detailed discussion with the DCR and the unified records coordinators (URC) regarding the new self-assessment process. They were eager to implement it correctly and in a way that would be beneficial to them. The most difficult aspect of this was their understanding of the somewhat subtle difference between <u>assessing</u> whether substantial compliance was met versus <u>engaging</u> in activities to meet substantial compliance. After the discussion, the staff said that they now had a better understanding of what to do for the section V self-assessment.

	The self-assessment for section V included relevant and reasonable self-assessment activities, though it did not include all of the activities that it should have included. For example, V1 only referred to the URC monthly audits. It did not include anything about a review of policies, aspects of the unified record contents, and so forth. Similarly, the self-assessment activities for V2 did not include anything about staff training on policies. For V3, the DCR also used the monthly audits, however, there were many other activities that should have been included, such as the table of contents review, and graphing of outcomes. The monitoring team recommends that the DCR and URCs review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead them to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." The monitoring team and the QA director engaged in detailed discussion about this during the onsite review. The self-assessment activities and the action plans should also line up with each other. The action plans for section V included relevant actions and steps, but not all of the actions and steps that will need to be addressed in order to achieve substantial compliance. As the DCR and URCs work on developing a self-assessment process for section V, they should consider these points: • Be comprehensive. Many provision leaders tended to rely primarily on the statewide self-monitoring tools and/or list of action plans. These tools can be one of the activities used to self-assess, but will not likely be sufficient for most provision items and the action plans may not always address everything that needs to be addressed. • Not self-rate substantial compliance solely on a score of over 70% on the statewide self-monitoring tools. • Be described in detail so that the reader can understand what it is that they did. • Line up with what the monitoring team assesses as indicated in this report. The monitoring team looks at many things during its assessment of each provision item. Thus, the monitoring team recommends that the DCR and URCs review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. • Identify the samples chosen. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the DCR and URCs and wants believes that the facility was proceeding in the right direction. This was a good first step. The facility self-rated itself as being in noncompliance with provision items V1, V3, and V4. The monitoring team agreed with these self-assessments. The facility self-rated itself in substantial compliance for V2. The monitoring team did not agree for the reasons detailed in the report narrative below.

	Summary of Monitor's Assessment: MSSLC demonstrated continued progress towards substantial compliance in some areas of this provision, however, there were some areas in which there was no progress. Progress was most notable in the responsiveness to the many, but not all, of the recommendations in the previous report. Lack of progress was a result, in part, of the discontinuation of some of the previous department activities, such as graphing and trending of data. The director of client records (DCR) and the Unified Records Coordinators (URC) continued to be responsible for recordkeeping activities. Overall, the active records were organized and well maintained. The record clerks did a good job of managing the active records. There continued to be a need for further improvement in all current documents being in the record (i.e., what MSSLC called delinquent documentation), legibility of entries, and proper signatures, as required by Appendix D. Some IPNs had entries other than only handwritten notes. The facility should examine this and create an acceptable and agreed upon standard for MSSLC. A standardized new observation note was created. It was nine pages. As a result, there were lots of empty spaces, and moreover, a new binder had to be added to the active record for every individual to store these. MSSLC made good progress in the use of the individual notebooks. This was due, in part, to the creation of work groups to address their use, policies and procedures, staff training, and regular monitoring. Overall, the general consensus among managers, and the monitoring team, was that the individual notebooks were being used and were helping staff to do their jobs. Master records were in place for every individual. Many, however, needed to be organized according to a standard table of contents. There was still no satisfactory resolution as to what to do when items that should be in the master record could not be located. There was a one-page spreadsheet that indicated the status of state policies for each provision of the Settlement Agreement, and the facility-specific policy that related to each of these state policies. It should be expanded to include relevant aspects of the DADS memo from the assistant commissioner. A system to show training of relevant staff on both the state policies and the facility-specific policies was needed. The URC monthly audits were conducted as frequently as required, in a consistent manner, and on the proper forms. A number of improvements occurred since the last review and are noted in the report below. At the end of each month, the DCR took the needed corrections for all of the audits and put them into a single document. This document was then sent out to all relevant managers and clinicians with a request for them to respond to those items that were their responsibility. When a reply came back, the DCR forwarded that information to the URCs. And that's where the process ended. That is, there was no follow-up activity after the audit results were sent out by the DCR. The monitoring team recommends that the URCs create a set of graphs as described in V3, and that these graphs be included in the MSSLC QA program.

	The DRC and the URCs recently received the list of actions and topics that were now to comprise V4. The monitoring team discussed these at length during the onsite review. The actions should now set the occasion for MSSLC to be able to more directly address the requirements of V4.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	MSSLC demonstrated continued progress towards substantial compliance in some areas of the four items of this provision, however, there were some areas in which there was no progress. The director of client records (DCR) and the Unified Records Coordinators (URC) continued to lead the departmental activities. The DCR participated in the facility's PET and QAQI Council activities. She raised topics relevant to section V. Progress was most notable in the recordkeeping staffs' responsiveness to the many recommendations and suggestions in the previous report. The DCR and URCs directly addressed most of those topics as noted below in this report. The DADS statewide policy remained in effect. In addition, there were three facility-specific policies. Adm-06 was the slightly updated from the time of the last onsite review. Two other policies mentioned in the previous two monitoring reports were abandoned in favor of two other new facility-specific policies, both regarding the implementation and monitoring of the individual notebooks. The monitoring team has three comments regarding the facility-specific policies. • It was good to see policies result from the activities of the individual notebook task force. • There were numerous formatting errors in Adm#6 that should be corrected. Doing so will avoid later confusion. Errors included the footer saying "Revised 8/24/11" while the first page header said 12/1/11. In a few other places, the correct outline letters were missing (e.g., an A or a B). Also, the individual notebook record order and guidelines were different in Adm#6 and Adm#8. These should be the same. • At MSSLC, there were a number of books and binders in which important information was kept and in which important data were recorded. A list of eight of these was given to the monitoring team (e.g., clothing inventory, food intake book, bowel movement book). The facility policies need to be updated to reflect the use and existence of these systems, too.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Active records Overall, the active records were organized and well maintained. The record clerks did a good job of managing the active records. In addition, the DCR and URCs had implemented recommendations from the previous monitoring report regarding the use of the nursing section sub-dividers for all active records and the full consideration of the creation of one records room per unit. This was fully explored and, after much consideration, a good decision was reached to continue with a record room in each home. They were still working on two other recommendations: identifying what consents were needed and getting social histories written and into the active records. There continued to be a need for further improvement in all current documents being in the record (i.e., what MSSLC called delinquent documentation), legibility of entries, and proper signatures, as required by Appendix D. Many documents were not submitted for filing or were submitted late. Data regarding delinquent documentation were not being kept by the DCR and URCs as they had been last time, even though work was being done every Friday by the record clerks to address this problem. A system of requiring the home clerks to track the submission of monthly progress notes was continued from the time of the last review. The results of this tracking were graphed last time, but this was also not continued. Without data, trending as recommended in the previous report, could not be done. Below are additional points regarding the active records: • Some IPNs had entries other than only handwritten notes. For example, the dental department inserted the comprehensive exam into the IPNs. In general, the standard is to not allow emails, memos, and so forth to be included in the integrated progress notes. On the other hand, some departments sometimes typed an IPN on an IPN form and then inserted it into the IPN in a way that did not disrupt the chronological flow (i.e., they crossed off any previous blank lines, inserted the IPN with their entry typed at the top of the page and then other clinicians continued from the single typed entry by writing their new entries below the typed entry). The URCs reported that this process worked well and had resulted in some improvement in legibility of entries (though no data were summarized as noted above and in V3 below). The facility should examine this and create an acceptable and agreed upon standard for MSSLC, which may allow for some of what was already occurring. • Since the time of the last onsite review, a new observation note was created. It was nine pages and was standardized across the entire facility. As a result, there were lots of empty spaces, and moreover, a new binder had to be added to the active record for every individual to store these. Fortunately, the director of	

#	Provision	Assessment of Status	Compliance
		home life and training already formed a work group to review and modify this. <u>Individual notebooks</u> MSSLC made good progress in the use of the individual notebooks since the last onsite review. This was due, in large part, to the creation of work groups to address the use of the individual notebook, create policies and procedures, implement staff training, and implement regular monitoring by the AAUDs and within the MSSLC Active treatment monitoring and coaching guide tool. The AAUD tool was 15 questions and the data were summarized on a table for the Whiterock unit. In addition, the decision was made to have staff carry and be responsible for individual notebooks, not individuals. If an individual wanted his or her own individual notebook, a duplicate was made for him or her. As a result, the general consensus among managers, and the monitoring team, was that the individual notebooks were being used and were helping staff to do their jobs. <u>Master records</u> Master records were in place for every individual. Many, however, needed updating and to be organized according to a standard table of contents. The DCR and URCs reported that they had the table of contents from state office and were going to add to it to create the MSSLC table of contents. Once they completed that task, they would update all of the records. They planned to have this completed by the next onsite monitoring review. There was still no satisfactory resolution as to what to do when items that should be in the master record could not be located. To address this, the monitoring team recommends that there be some sort of procedure, rubric, flow chart, or guideline that the DCR and URCs can follow that would indicate how to obtain any missing items and how to document their actions to show their efforts, even if the document cannot be located. <u>Shared drive</u> The URCs showed the monitoring team the shared drive system of documents. This will be reviewed in more detail at the next monitoring visit. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
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	MSSLC had a one-page spreadsheet that indicated the status of state policies for each provision of the Settlement Agreement, and the facility-specific policy or policies that related to each of these state policies. Not all state policies were yet in place, though continued progress was evident.	Noncompliance

#	Provision	Assessment of Status	Compliance
	develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	The spreadsheet, however, should be expanded to include any relevant aspects of the DADS memo from the assistant commissioner, dated 2/15/12, such as, at a minimum, whether or not the facility-specific policy was reviewed by state office (though this was no longer a DADS requirement). To show implementation and training of relevant staff on both the state policies and the facility-specific policies, the facility should develop a policy and system that: • Incorporates mechanisms already in place, such as an email/correspondence. • Notes the list of job categories to whom training should be provided. • Defines, for each policy o who will be responsible for certifying that staff who need to be trained have successfully completed the training, o what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and o what documentation will be necessary to confirm that such training has occurred. Some of this responsibility may be with the Competency Training Department. • Includes timeframes for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training). • Includes a system to track which staff completed which training.	
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	Overall, the reviews continued to be 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, as well as other information from their notes, 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. After the URCs completed these documents, the DCR took the list of needed corrections for all of the audits and put them into a single document, with a section for each individual whose record was audited. This document was then sent out to all relevant managers and clinicians with a request for them to respond to those items that were their responsibility. When a reply came back from the manager or clinician, the DCR forwarded that	Noncompliance

#	Provision	Assessment of Status	Compliance
	possible reoccurrence.	information (usually an email) to the URCs. And that's where the process ended. Before discussing improvements that are needed, the monitoring team wants to note some improvements that occurred since the last review. • Master records were being included in the monthly audits. • Individual notebooks were included for all individuals reviewed. • Both the document present and guidelines followed columns were filled out. • A list of medical consultations was used to audit whether documentation was in the active record. The URCs reported that Dr. Ellis was very helpful in their setting this up. Furthermore, in addition to using the consultation list when doing audits (a) the lists was sent each month to the unit record clerks so that they could check on every consultation documentation, and (b) they had incorporated lab results and x-rays into this process, too. Improvements were needed in the conduct of the monthly audits in the following ways: • There was no follow-up activity after the audit results were sent out by the DCR. Sometimes the manager or clinician responded, sometimes he or she didn't. There was no action taken by the DCR after she sent out the list of corrections. Some sort of system for follow-up needs to be put in place. o Also, the DCR should consider assigning each needed correction to the appropriate manager or clinician instead of having each of them have to read the entire list and determine which items were their responsibility. One way to do so would be to color code each item. The San Antonio SSLC URC had a way of doing this that might be of interest to the DCR. • Errors that were about legibility, signatures, credentials, and so forth were not noted as errors in the URCs' corrections lists and, therefore, not included in the list of feedback/corrections sent out to the managers and clinicians. They did, however, rate these areas in the statewide self-monitoring tool because there were specific items in the tool related to these topics. • For the master record portion of the audit, many of the items were optional and did not apply to many individuals. Therefore, an item scored "no" did not indicate whether this was an item that did not need to be there (i.e., not applicable) or whether it should have been there, but wasn't. Therefore, the URCs should revise this form to have three columns: yes (i.e., present), no (i.e., should be in the master record, but wasn't), and NA (i.e., not needed). • Consider whether the monthly audit should include anything about the shared drive contents for the individuals being audited. Some activities that were conducted at the time of the last monitoring review were discontinued. All of these should be re-started. First, unit record clerks had been	

#	Provision	Assessment of Status	Compliance
		conducting an audit of one active record each month. Second, the URCs had been writing a summary of concerns based upon their audits each month. Third, the recordkeeping staff had discontinued doing any graphing of important recordkeeping-related data. The monitoring team recommends that the URCs create a set of graphs as follows, and that these graphs are included in the QA program: • Number of reviews done per month • Average score on the statewide self-monitoring tool • Average score on the statewide self-monitoring tool only including those items that have been problematic (i.e., the items regarding legibility, signatures, etc.). • The average number of errors per table of contents review • The average number of errors that were not corrected as of the cut off date (e.g., two months). • Amount of delinquent documentation. • Consider whether to graph the data from the AUDD individual notebook monitoring tool, the individual notebook portion of the MSSLC Active treatment monitoring and coaching tool, and/or the results of unit record clerk audits (if these are restarted). • Data should be presented unit-by-unit (and perhaps by department/discipline) as well as for the facility as a whole.	
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.	Recently, the monitoring teams, DADS, and DOJ agreed that a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item. The DRC and the URCs recently received this list and the monitoring team discussed it at length during the onsite review. It is likely that the DADS state office coordinator for recordkeeping will provide additional direction and guidance to the DRC and URCs. The actions are below and MSSLC should now be able to more directly address the requirements for this provision item. <u>Records are accessible to staff, clinicians, and others</u> MSSLC was not yet self-assessing this. The monitoring team, however, observed that: • The physicians were using the records: o IPN entries were in SOAP format o Consults were documented in the IPN o Labs were being documented o Hospital notes (pre-transfer) were found o A new hospital D/c note form was created • Several records had info that included notes such as “Not a part of the formal record,” but the documents were nonetheless placed in the record. Several of these were drug monographs from the pharmacists given to the physician for	Noncompliance

#	Provision	Assessment of Status	Compliance
		informational purposes only. Other were just miscellaneous documents placed in the records. • Records were available during psychiatry clinic and staff referred to them and reviewed documentation. • Individuals' records and notebooks were available and accessible to nursing staff. • The individual notebooks appear to be consistently accessible to staff and psychologists. • Current ISPs were available in most, but not all, of the records. • Habilitation clinicians reported difficulty in accessing the record at times to ensure timely documentation. As a result they devised a system of Activity Plans. Some clinicians then duplicated the same information on the Activity Plans and in the IPNs, thus, making the task far more time consuming and redundant than it should be. <u>Data are filed in the record timely and accurately</u> MSSLC was assessing this during the monthly audits, that is, when the URCs indicated whether a document was in the record, up to date, and in the right place. The availability of documents in the shared drive, including assessments that are due 10 days prior to annual ISP meetings will be reviewed during the next onsite review. <u>Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> MSSLC was not yet self-assessing this. The monitoring team, however, observed that: • Some data were documented/recorded timely on tracking sheets (e.g., vital signs, blood glucose levels), and some were not (e.g., weekly weight, individuals' response to SAM questions, individuals' response to PRN administration of medications). • Only 17% of the PBSP datasheets reviewed were completed in a timely manner during in-home and in-day program observations. • Data were not appropriately chosen to facilitate medication efficacy. In order for psychiatrists to make evidence-based driven decisions, this information must include time lines and medication change information in relation to the reason of selecting such agent (e.g., psychotic symptoms such as hallucinations for an individual with a psychotic disorder). • A review of a sample of quarterly reviews did not confirm that data were available for teams to consider when determining if a plan was adequate. • Data sheets for PT interventions were noted for the few individuals who received this service. The data collected, however, were not always specifically related to the established goals.	

#	Provision	Assessment of Status	Compliance
		<u>IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> MSSLC was self-assessing this as part of the statewide self-monitoring tool. To do so, the URCs answered a question related to this item, however, there was no explanation as to how they arrived at their rating. In addition, the monitoring team observed that: • It appeared that the physicians did utilize the records and reviewed documentation from other disciplines. • Nurses' notes usually indicated that they were documenting some type of follow-up to an identified health problem, however, they rarely indicated whether or not their current subjective/objective findings and assessments were consistent with or a departure from the prior findings/assessments. • Staff indicated the BPRS was the measure utilized to capture psychiatric target symptoms, but this was not reflected in the record as the driving component in making treatment decisions for medication efficacy. • Progress notes for direct therapies, wheelchair clinic, and some other limited actions taken by therapists were noted. These were often not complete, but were notations of completion of assessment, or to document that an individual participated in a walking program, for example. <u>Staff surveyed/asked indicate how the unified record is used as per this provision item</u> • The URC conducted a brief, but informative, interview with one IDT member each month for one of the individuals who was audited. The results of these interviews were not given to the monitoring team and it was not clear how, or if, the results were used in any way by the facility. • Physicians reported that they could provide better care if they had an electronic record. They reported that they found the current record system to be a hindrance to care. • During interviews with nurses, they consistently reported use of the 24-hour report and follow-up log as their sources of information when making care, treatment, and training decisions. They rarely, if ever, reported using the unified record for those purposes. • There were numerous items completed that would have been useful in the psychiatry clinic (e.g., results of QDRR, EKG results, physician's medical evaluation, neurology consultation). As a result, the psychiatrist did not approach the case review with consideration of these findings. • The record was clearly used for extensive record review in the completion of OT/PT/SLP and PNMT assessments.	

#	Provision	Assessment of Status	Compliance
		Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item, and data are reported rather than only clinical impressions MSSLC was not yet assessing this, however, the monitoring team found the following: • During the ISP meeting for Individual #415 the RN case manager had volume 2 of his active record opened and in front of her. • At the ISP meeting attended by the monitoring team for Individual #597, the unified record was used throughout the meeting to reference particular data to inform the IDT and to help them make care/treatment/training decisions. • The PNMT meeting was conducted without the availability of the record to check current status or for other reference. • The paper work task placed upon psychiatrists, including the current arrangement of handwriting information, often resulted in illegible and incomplete quarterly documents • Psychologists were not observed using the unified record to make treatment decisions, though it is possible that they did so. • The quarterly review form included a section to note progress or regression on all service and training objectives. It was not evident that this process was thorough enough to adequately assess the progress and efficacy of the related interventions. Monthly and quarterly reviews indicated that IDTs were continuing outcomes regardless lack of progress or when regression was apparent.	

Recommendations:

1. Fix the formatting and other errors in Adm#6 and Adm#8 facility-specific policies (V1).
2. Incorporate the facility's use of other types of data books and binders into the facility-specific policies (V1).
3. Address legibility, signatures, and delinquent documentation because the facility's efforts had not yet led to a satisfactory outcome, even though progress had been made. Establish a way to determine if these areas have improved to a level that meets criterion (V1).
4. Resolve the topics of: content of consents, and the need for social histories in the active record (V1).
5. Create a standard as to what should, and should not, be in the IPNs (V1).
6. Review the use of the lengthy daily observation notes (V1).
7. Put all of the master records into the new format following the new table of contents (V1).

8. Have a standard procedure for dealing with items that are missing from the master record (V1).
9. Expand the spreadsheet to include relevant information from the assistant commissioner's email on 2/15/12 (V2).
10. Create a process for the implementation and training of relevant staff on state and facility-specific policies (V2).
11. Follow-up on monthly URC audits of the unified records (V3).
12. Have three scoring options for the master record tool (V3).
13. Consider whether/how to include legibility, signatures, etc. in the error and correction system (V3).
14. Re-start the unit record clerk monthly audit of an active record, and the URCs' monthly summary of concerns (V3).
15. Determine how to include the shared drive in the audits of the unified records (V3).
16. Implement and monitor all of the aspects of assessing the use of records to make care, treatment, and training decisions, that is, the six areas highlighted with underlined headings in section V4 (V4).

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
AAUD	Administrative Assistant Unit Director
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABX	Antibiotics
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
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
AMS	Annual Medical Summary
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AOD	Administrator On Duty
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
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
AV	Alleged Victim
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
BPD	Borderline Personality Disorder
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BPRS	Brief Psychiatric Rating Scale
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
CIN	Cervical Intraepithelial Neoplasia
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
CPT	Certified Psychiatric Technician
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	Development Center
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff

DD	Developmental Disabilities
DDS	Doctor of Dental Surgery
DES	Diethylstilbestrol
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
DRM	Daily Review Meeting
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)
EC	Enteric Coated
ECG	Electrocardiogram
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
FLACC	Face, Legs, Activity, Cry, Console-ability
FNP	Family Nurse Practitioner
FNP-BC	Family Nurse Practitioner-Board Certified
FOB	Fecal Occult Blood
FSA	Functional Skills Assessment
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
GB	Gall Bladder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GFR	Glomerular filtration rate
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
HMO	Health Maintenance Organization
HMP	Health Maintenance Plan
HOB	Head of Bed
HOBE	Head of Bed Evaluation
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
ICA	Intense Care Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ID	Intellectually Disabled
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
ISPA	Individual Support Plan Addendum
IT	Information Technology
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KUB	Kidney, Ureter, Bladder
L	Left
L	Liter
LA	Local Authority
LAR	Legally Authorized Representative
LD	Licensed Dietitian

LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOC	Level of Consciousness
LOD	Living Options Discussion
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LTAC	Long Term Acute Care
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
MHA	Masters, Healthcare Administration
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
MOT	Masters, Occupational Therapy
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
MPT	Masters, Physical Therapy
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
NIELM	Negative for Intraepithelial Lesion or Malignancy
NL	Nutritional
NMC	Nutritional Management Committee
NMES	Neuromuscular Electrical Stimulation
NMS	Neuroleptic Malignant Syndrome
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
NPR	Nursing Peer Review
O2SAT	Oxygen Saturation
OBS	Occupational Therapy, Behavior, Speech
OC	Obsessive Compulsive
OCD	Obsessive Compulsive Disorder
OCP	Oral Contraceptive Pill
ODD	Oppositional Defiant Disorder
ODRN	On Duty Registered Nurse
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
PAD	Peripheral Artery Disease
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCFS	Preventive Care Flow Sheet
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
QMS	Quarterly Medical Summary
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNCM	Registered Nurse Case Manager
RNP	Registered Nurse Practitioner
RO	Rule out
ROM	Range of Motion
RPH	Registered Pharmacist
RPO	Review of Physician Orders
RR	Respiratory Rate
RT	Respiration Therapist
RTA	Rehabilitation Therapy Assessment
RTC	Return to clinic
RX	Prescription
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication

SAMT	Settlement Agreement Monitoring Tools
SAP	Skill Acquisition Plan
SASH	San Antonio State Hospital
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SDP	Systematic Desensitization 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
SIDT	Special Interdisciplinary Team
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
S/P	Status Post
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
TAC	Texas Administrative Code
TAR	Treatment Administration Record
TB	Tuberculosis
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TDAP	Tetanus, Diphtheria, and Pertussis
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

TX	Treatment
UA	Urinalysis
UD	Unauthorized Departure
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
VRE	Vancomycin Resistant Enterococci
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