United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of Onsite Review: September 24 – September 28, 2012

Date of Report: November 30, 2012

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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.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. 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.

(c) **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. 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.

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

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 again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at MSSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The facility director, Mike Davis, set the tone for the week and was supportive of the monitoring team's activities. The Settlement Agreement Coordinator, Etta Jenkins, again did an outstanding job, ensuring that the monitoring team was able to conduct its activities as needed. She was readily available and very responsive.

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 services and supports at the facility.

- Becoming a forensic facility: One of the challenges at MSSLC was meeting its mission to provide supports and services under its designation as a forensic facility. To that end, facility management was working to implement state policies and procedures, follow regulatory requirements, and work towards substantial compliance with the Settlement Agreement, all with consideration of the forensic population, as well as the 75 or so individuals who were not designated as part of the forensic population. A set of consultants was helping to develop a plan for moving forward. It included staff training, meetings, observations, and a pilot project.

- Quality assurance: To move forward towards substantial compliance, MSSLC needs to have a functioning, active, and comprehensive quality assurance program. It is not only a requirement of section E, but also necessary to provide support for the facility to engage in activities to meet all of the other sections of the Settlement Agreement.

- New ISP process: The ISP process was again updated. It may take some time for it to be fully implemented across the facility.

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.

Restraint

- The facility had made good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. All requirements of the new DADS statewide policy had not yet been implemented, particularly in regards to protective mechanical restraints used for self-injurious behavior and medical restraint.
- The total number of restraints used for crisis intervention had increased slightly since the previous monitoring visit. There were 280 physical restraints used for crisis intervention and there had been five chemical restraints used for crisis intervention. Restraints for individuals with the highest number of restraints six months ago had significantly decreased. This was attributed to a targeted focus on programming and treatment for those individuals.
- Two major projects had been initiated at the facility. One, funded by the Hogg Foundation aimed at reducing the number of behavioral incidents and restraints at the facility. The second was consultation from a team of forensic experts to address service delivery and programming at the facility. Both projects were in the initial phases of implementation, so progress (and possible effects) could not yet be measured.

Abuse, Neglect, and Incident Management

- From 6/1/12 to 8/31/12, there were 17 confirmed cases of physical abuse, 1 confirmed case of sexual abuse, 4 confirmed cases of verbal/emotional abuse, and 48 confirmed cases of neglect. These were the results of DFPS investigations of 2208 allegations (743 allegations of physical abuse, 427 allegations of sexual abuse, 574 allegations of verbal/emotional abuse, 13 allegations of exploitation, and 451 allegations of neglect).
- There were 576 injuries reported in the quarter 6/1/12 - 8/31/12. These included 18 serious injuries resulting in fractures or sutures. The facility needs to aggressively address trends in injuries and implement protections to reduce these incidents and injuries.
- Some positive steps taken to address the provision items of section D included:
    - The tracking system for investigation and follow-up had been improved.
    - New "Zero Tolerance" posters related to abuse, neglect, and retaliation were placed throughout the facility.
    - A/N/E trends were now being presented at quarterly QAQI Council meetings and monthly unit meetings.
    - The Employee Reassignment Center (ERC) had been restructured to operate 24 hours a day/7 days a week to allow alleged perpetrators to work their regular shift. This also allowed DFPS investigators to set up more timely interviews with APs.

Quality Assurance

- There was little progress in the development of a quality assurance program at MSSLC. The new QA director, Kim Kirgan, was assigned to other tasks during the past six months. There was, however, a plan for a re-organization of assignments and she will likely have more time to devote to the QA program.
- The QA data list inventory was identical to what was submitted six months ago (except for the medical tab).
- The QA plan narrative needed much work to be adequate and useful to the reader. Suggested headings and organization are provided in the report below. The QA plan matrix was identical to what was submitted six months ago. The QA plan matrix should include all key important indicators (i.e., measures, data), that is, a mix of process and outcome indicators for each section of the Settlement Agreement (i.e., each discipline department).
- The monitoring team recommends there be a monthly meeting of the QA director, SAC, and the lead person responsible for each provision of the Settlement Agreement.
- The QA department had begun a QA report, however, the contents were not presented in a coherent easily consumable manner for the reader. A successful QA report should describe the quality and status of each department/section. Recommendations for format and organization, important indicators/data, and editorial are provided below.
- MSSLC continued to hold a series of QA-related meetings that had been running for about one year. This seemed like a good system for reviewing data at MSSLC. The meetings were the PITs, PETs, QAQI Council, and Executive Management.
- It appeared that the progress reported on CAPs and the management of CAPs in the previous monitoring report had not been maintained. Note, however, that the absence of an organized system of CAPs management did not mean that the facility took no actions. For instance, much activity was occurring around medical, aggression, and ISP topics.

Integrated Protections, Services, Treatment, and Support

- DADS state office recognized that the previous ISPs did not meet the requirements of the Settlement Agreement. In consultation with the parties, it was agreed that beginning in August 2012, the monitoring teams would only review and comment on the ISP documents that utilized the newest process and format. The new ISP process had not been completed for any individuals at MSSLC.
- There had, however, been some positive steps forward with the new ISP process.
    - The QDDP department was tracking completion on annual assessments and attendance at the ISP meetings.
    - ISP Coordinators had been reassigned to conduct the annual ISP meetings and ensure that information discussed at the meeting was included in the ISP.
    - QDDPs and Admission /Placement staff had received training on the Most Integrated Setting Policy and the CLDP process.
    - Training had begun on the new ISP process.
- The monitoring team observed one annual ISP meeting in the new format. The IDT was not yet competent at developing an integrated plan that included all needed supports and services based on preferences and needs of each

individual. It was apparent that the IDT was attempting to follow the format of the new ISP process and include all required information in the plan. The team, however, did engage in a much more integrated discussion of his preferences and needs.

Integrated Clinical Services

- The facility made forward, incremental progress in this area, but there was no policy to guide this procedure and no adequate means of assessing progress. MSSLC had not implemented any facility initiative that was intended to specifically foster integration among the clinical disciplines.
- The monitoring team had the opportunity to meet with the medical director and medical compliance nurse to discuss integration activities at the facility. During this meeting, it was evident that some degree of integration was occurring. It was equally as evident that there was no overarching plan for how MSSLC would achieve integration of clinical services. Integration had not been defined and, therefore, could not be adequately measured.
- Throughout the week of the review, the monitoring team encountered a few good examples of integrated clinical services. Areas where integration was needed, but failed to be evident were also noted.

Minimum Common Elements of Clinical Care

- The facility made very little progress in this area. During discussions with the medical director, data were provided for medical and pharmacy assessments. Other clinical areas were not included.
- A set of clinical indicators was developed shortly before this review. Additional indicators are needed and indicators must be developed for all of the clinical services. Much of the work that needed to be done in this area will hinge on the development of a robust set of indicators that can be utilized across the continuum of treatment and evaluation of treatment.

At-Risk Individuals

- Progress had been made through an initial attempt to ensure all individuals were accurately assessed and action plans were in place to address risks, however, adequate plans were not in place to address all risks identified. Risk action plans were not being consistently reviewed and monitored.
- Key department heads from MSSLC recently attended training in Austin on the new risk process. Consultants from the state office will be providing additional training to IDTs at MSSLC in the near future.
- As noted in section F, assessments were not being consistently completed prior to ISP meetings. Teams could not adequately discuss risk factors without current, accurate assessments in place.
- Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs.

Psychiatric Care and Services

- MSSLC was in noncompliance for all 15 sections of provision J of the Settlement Agreement. The role of the lead psychiatrist was not clear to the monitoring team. There was no longer a consulting psychiatrist with expertise in serving minors.
- The completion of psychiatric assessments, both quarterly and Appendix B comprehensive evaluations, had progressed, but more work was needed. The monitoring team calculated that 87% of the evaluations, as described in Appendix B.
- 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. For about half of the cases, follow-up consultations were conducted frequently throughout the period from 3/8/12 to 9/8/12. In fact, individuals were evaluated up to six times during this time period by the psychiatrist. This was notable of advancement being made in this section.
- The psychiatrists informed the monitoring team of what they considered to be a tedious exercise to type the information into an electronic QPMR form. Further, during one of the clinics, even when the IDT articulated that an individual did not have an accurate diagnosis and or indication to continue the medication, the psychiatrist proceeded with giving the individual medication, did not amend the documentation, and did not correct the diagnosis because of the paperwork task. This type of approach to the treatment of individuals at MSSLC was alarming and did not meet generally accepted professional standards of care in psychiatry.
- The facility did not administer a Reiss screen for a change in status. There should be a rescreen if there is a change in status. A database was designed to track the administration dates and scores of the MOSES and DISCUS. The facility must calculate its own percentage of individuals who were examined in a timely fashion and report these findings in the facility self-assessment.
- There were onsite neuropsychiatric clinics that took place at MSSLC since last review and during the week of the onsite visit. The neurologist was unaware of the Settlement Agreement. The solo approach of the neurologist (e.g., not working through the IDT process) defeated the whole purpose of the neuropsychiatric consultation.

Psychological Care and Services

- Improvements since the last onsite review included the expansion of the collection of inter-observer agreement data, improvements in data collection reliability, and improvement in the comprehensiveness of the full psychological assessments. In addition, there was continued improvement in the establishment of evidence-based curriculums, goal directed services, and measurable treatment objectives for psychological therapies, other than PBSPs. The psychology department established biweekly training of DCPs on the implementation of individual PBSPs.
- The psychology department needed to expand the collection of IOA data for target behaviors, establish IOA target levels, and ensure achievement of those levels; and document the collection of data reliability, establish data collection reliability goals, and ensure that those levels are achieved. The department also needed to increase the percentage of

functional assessments completed for individuals with PBSPs, and ensure that all functional assessments include a clear summary of the variables hypothesized to affect target behaviors. All PBSPs need to include functional replacement behaviors that are based on the hypothesized function of the target behavior.

Medical Care

- The medical department made continued progress in the provision of medical services. This was largely based on the strength of a few long term and very capable members of the primary care medical staff.
- In terms of the provision of medical care, the facility continued to have good compliance with immunization administration, vision and hearing screenings, and some preventive care. Compliance with some cancer screenings increased.
- The department, however, appeared to be in a state of disarray and was incapable of demonstrating the progress that was made. Data management remained problematic and many document requests were simply not fulfilled or inadequately fulfilled.
- Seizure management was a cause for concern. There was no adequate forum for neurology-psychiatry clinic and the neurologist conducting the onsite clinic had little to no knowledge of any of the issues specified in the Health Care Guidelines.
- The facility made no progress in the development of a medical quality program and there appeared to be little enthusiasm for doing so.

Nursing Care

- MSSLC sustained many of the improvements made six months ago and continued to make progress. The Nursing Department broadened its scope of monitoring and implemented real-time reviews of nursing assessments and care of individuals with acute changes in their health status. There were steps taken to improve not just the presence of documents, such as assessments and health care plans, but the quality of these important tools.
- 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.
- Notwithstanding these positive and notable findings, there was much work to be done. It was revealed during the review of individual's records that there continued to be 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 continued to be nurses who failed to consistently implement the assessment and reporting protocols for the majority of the individuals reviewed.
- Improvements in medication administration management resulted in a substantial rating for M6.

Pharmacy Services and Safe Medication Practices

- Significant progress was made in the provision of pharmacy services and safe medication practices under the leadership of the pharmacy director. During her one-year tenure, a series of changes had been implemented that were beginning to have a considerable impact on many practices in several departments.
- The documentation of communication between the pharmacists and prescribers improved, although the actual number of interventions appeared somewhat low. The facility successfully implemented the Intelligent Alerts in June 2012, but no system had been developed to provide documentation to show that this was actually completed for each new order when indicated.
- The QDRR process was greatly improved relative to content and medical staff response times. This was largely in response to process changes in which the evaluations became available electronically for review. The facility continued to have difficultly completing the MOSES and DISCUS evaluations.
- Adverse drug reactions were reported, but it was not clear that this information was being adequately analyzed for trends and patterns, although prior ADR data appeared to be the source of future DUEs. Drug utilization evaluations were completed as required and provided good information for facility staff.
- Progress was noted in the medication variance program.

Physical and Nutritional Management

- Minimal progress was made towards substantial progress with provision O. During the previous review, the monitoring team had expressed serious concern that the PNMT assessments were taking too long to complete. This continued to be the case.
- Further, referrals to PNMT were not being addressed in a timely manner.
- Mealtimes, position, and alignment were adequate in most cases, though one dining room was of significant concern due being short staffed, the DSPs not following the plans, and DSPs not knowing the health risks of the individuals.
- A number of individuals would likely benefit from modified dining chairs to accommodate their needs for support and alignment during meals. Day programs should be an area of focus for positioning monitoring and assessment.

Physical and Occupational Therapy

- Minimal progress was made related to this provision. The OT and PT clinicians appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment (e.g., wheelchairs), and to review other supports and services.
- Assessment content was found to be unchanged since the last review. The proper format was not consistently followed and the content for each of the areas assessed varied greatly. There was little analysis of findings and the summary section lacked in the presentation of the clinical reasoning used by the therapists for the development of interventions

and supports. There was no clear link to the mitigation of identified health risks and health or medical status over the last year in annual assessments.
- Findings of monitoring were not reported in the assessments. There was no formal audit of the assessments, no written content guidelines and no evidence of training for the clinicians to ensure competency.
- There were a small number of interventions provided by the clinicians and a small number of SAPs. Documentation, however, was inconsistent and there was insufficient rationale provided to continue or discharge from services. Interventions were not well integrated into the ISP process.

Dental Services

- The dental clinic made progress since the previous review. The dental director and administrative assistant were very focused and dedicated to improving services for the individuals. They collected data and had information, which they believed would demonstrate the work done in an effort to move towards substantial compliance.
- The facility continued to provide basic dental services onsite, while more advanced services were provided at a local hospital. Many individuals had restorative procedures completed at MSSLC. Sedation and general anesthesia were not used at MSSLC and there was no plan to do so.
- The oral hygiene ratings for the facility improved, but many of the records and documents included information indicating that oral care in the homes was not optimal. Training for direct care professionals was ongoing.
- Comprehensive dental assessments were required every six months. Most met this timeline. Compliance with the annual requirement was 97%. This was a significant improvement for the facility.

Communication

- Assessments had been completed for each individual, but the quality of those was poor. The current ratio for caseloads continued to be high. Consideration of those with extensive experience with AAC and adults with developmental disabilities is critical.
- The therapists are encouraged to step up their efforts to immerse themselves into the routines of the individuals they support to capitalize on the teachable moments with staff so that they may learn to capture teachable moments with individuals.
- Group and individual activities should be routinely co-directed by speech clinicians and DSPs in the homes, work, and day program environments.
- SLPs should participate in co-designing written programs and providing formal training. Implementation should be collaborative with demonstration in real time activities. There was no collaboration of speech and psychology or integration in the PBSPs or ISPs.
- NEO training was very limited related to communication and increasing the time allotted to this should be considered. Training should focus on teaching staff to be effective communication partners as well as to implement AAC.

Habilitation, Training, Education, and Skill Acquisition Programs

- Improvements since the last onsite review included an increase in the number of SAPs that included a rationale that clearly stated how acquiring this skill was related to the individual's needs/preference. There was the initiation of an interdisciplinary team to develop plans to decrease dental/medical sedation, and there was expanded collection of SAP treatment integrity.
- Areas of focus for the next six months should include ensuring that each SAP has a plan for maintenance and generalization that is consistent with the definitions in the report. In addition, the facility should collect relevant data regarding the educational services received by MSSLC individuals. There should be work done so that individualized assessments of preference, strengths, skills, and needs impact the selection of skill acquisition plans. The staff should review the treatment integrity tool to ensure it reflects both accurate implementation and documentation of SAPS, identifies target levels of integrity, and ensures the achievement of those levels. Measures of skill training in the community need to be collected accurately, an acceptable percentage of individuals participating in community activities should be established, and training on SAP objectives in the community should occur.

Most Integrated Setting Practices

- MSSLC continued to make progress across all provision items of section T. The number of individuals placed was at an annual rate of more than 15% (28 since the last onsite review). Approximately 14% of the individuals at the facility were on the active referral list, that is, 50 individuals.
- There was progress in placing individuals who had been on the referral list for a long period of time, as evidenced in the reduction of the number of individuals on the referral list for more than 180 days and for more than one year. Further, individuals were being placed from all five units.
- Of the 21 individuals who received post move monitoring that was reviewed by the monitoring team, 20 (95%) transitioned very well and appeared to be having great lives. The high percentage of individuals who had a good transition and who were having good lives in the community demonstrated ongoing efforts by the admissions and placement staff and by the IDTs to continually improve the referral and placement process at MSSLC.
- Since the last review, four individuals had died since being placed. The APC should do a review of any and all of these cases. Similarly, data for individuals who had any untoward incidents were not being kept, but should be, for at least a one-year period after moving.
- Obstacles to referral and to placement need to be appropriately identified and there should be an action plan to address whatever obstacles were identified. MSSLC was engaging in some, but not all, of the activities required to educate individuals, LARs, family members, and the MSSLC staff about community living options.
- Overall, the quality of the CLDPs had improved. A CLDP meeting was held during the onsite review. It was the best CLDP meeting yet observed by the monitoring team. Improvements were needed in the list of essential and

nonessential supports to ensure the inclusion of every important aspect of MSSLC plans (e.g., PBSP, PNMP, dining plans), the individuals' desires to be employed, and skill acquisition plans. Further, all preferred activities and items should not be put into one single ENE support.

- Since the last review, 55 post move monitorings for 27 individuals were completed. They were completed on time, in the right format, and thoroughly. The APC and her staff must attend to the items bulleted in T2a regarding there being a high quality post move monitoring review document completed by all staff who conduct post move monitoring, and ensuring that all follow-up efforts are thoroughly documented and detailed.
- The discharge reports were improved from the last review, however, the important last section of the report, regarding referrals and/or necessary services required in new environment was not adequate in almost every report.

Guardianship and Consent

- Progress continued to be made. QDDPs received training on the new guardianship policy, and letters had been mailed to correspondents and family members concerning how to obtain guardianship. The Human Rights Officer had revised the rights assessment to include prompts that might lead to discussion on whether or not the individual had the ability to give informed consent in a number of areas.
- Although positive changes had been made to the assessment of functional decision-making capacity, given the complexity of such an assessment, the facility should coordinate its efforts with state office. The state is encouraged to finalize the consent policy, because it should assist the Facilities in moving forward with regard to the implementation of the section U Settlement Agreement requirements.

Recordkeeping Practices

- MSSLC demonstrated continued progress. The active records continued to be in good shape.
- Even so, there continued to be a need for further improvement. The main areas for improvement were documents missing from the active record (primarily ISP-related assessments and forms) and improving legibility of written entries. Documents were often taken out of the active record, often to be photocopied, but were either replaced in the wrong place in the active record, or not replaced at all.
- The master records were all updated to the new table of contents. They were in good form, consistent from record to record, and easy to use. Individual notebooks were being used.
- Five quality reviews (audits) were conducted in each of the previous six months. The reviews were done in a fairly consistent manner and were neatly and clearly documented. The typical number of corrections needed was around 11 to 12 per unified record. A set of other binders/logs needed to be added to these audits.
- No action was taken to explicitly address the six aspects of V4 that were reviewed during the last monitoring review.

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

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>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.</td><td>
Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o DADS Policy: Use of Restraints 001.1 dated 4/10/12
o MSSLC Self-Assessment
o MSSLC Provision Action Information Log
o MSSLC Section C Presentation Book
o FY12 Restraint Trend Analysis Report
o Sample of IMT Minutes
o List of all restraint by Individual 3/21/12 through 8/30/12
o List of all chemical restraints used for the past six months
o List of all medical restraints used for the past six months
o List of all restraints used for crisis intervention for the past six months
o List of all mechanical restraints for the past six months
o MSSLC “Do Not Restrain” list
o List of individuals with desensitization plans
o Desensitization plans for Individual #456, Individual #196, Individual #484, and Individual #372.
o Restraint Reduction Committee meeting minutes for past six months
o Special Restraint Review Tracking Log
o Training transcripts for 24 MSSLC employees
o Documentation for protective mechanical restraint for self-injurious behavior and ISP for Individual #16.
o Crisis Intervention Plans for Individual #309 and Individual #235
o ISPs, PBSPs, Safety Plan for Crisis Intervention (when applicable) and ISPAs for:
• Individual #56, Individual #365, Individual #436, Individual #589, Individual #373, Individual #483, Individual #441, and Individual #63.
o A sample of restraint documentation for crisis intervention including:

<table>
<tr><th>Individual</th><th>Date</th><th>Type</th></tr>
<tr><td>#56</td><td>7/18/12</td><td>Physical</td></tr>
<tr><td>#56</td><td>7/23/12@5:53pm</td><td>Physical</td></tr>
<tr><td>#56</td><td>7/23/12@5:37pm</td><td>Physical</td></tr>
<tr><td>#56</td><td>7/25/12</td><td>Physical</td></tr>
<tr><td>#56</td><td>8/1/12</td><td>Physical</td></tr>
<tr><td>#56</td><td>8/13/12</td><td>Physical</td></tr>
<tr><td>#365</td><td>4/22/12</td><td>Physical</td></tr>
<tr><td>#365</td><td>5/1/12</td><td>Physical</td></tr>
</table>
</td></tr>
</table>

#365	6/1/12	Physical
#365	7/14/12	Physical
#365	7/29/12	Physical
#365	8/10/12	Physical
#436	7/17/12	Physical
#436	7/22/12	Physical
#436	8/10/12@8:00pm	Physical
#436	8/10/12@8:07pm	Physical
#441	8/28/12	Physical
#63	8/27/12	Physical
#483	8/27/12	Physical
#589	8/4/12	Chemical
#589	6/9/12	Chemical
#373	7/21/12	Chemical

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
- Alynn Mitchell, Acting QDDP Coordinator
- Joy Lovelace, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 9/24/12 and 9/26/12
- ISP preparation meeting for Individual #94
- Annual IDT Meeting for Individual #151
- Shamrock PIT Meeting 9/26/12
- Longhorn PIT Meeting 9/27/12
- Restraint Reduction Committee Meeting 9/27/12

Facility Self-Assessment:

MSSLC submitted its self-assessment. It was updated on 9/6/12. 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 conducted a number of activities to assess compliance for each provision item. For example, to assess compliance with C1,

	• Psychology staff reviewed restraints using the statewide section C audit tool. • Reviewed restraint tracking and trending data. • Reviewed minutes from the Performance Improvement Team meetings. • Reviewed medical restraints to determine if teams were developing strategies for reduction and fading. • Reviewed data on pre-treatment sedation. • Reviewed data on protective mechanical restraints. These activities were similar to the activities engaged in by the monitoring team to assess compliance. The facility self-assessment commented on the overall compliance rating for each provision item based on assessment findings, as well as commenting on processes in place to address compliance with each item. The facility assigned a rating of substantial compliance to C2 and C3. The facility met substantial compliance with C2 and C3. The facility rated the other provisions in C as noncompliant. The facility rated C8 as noncompliant due to conflicting audit data reliability even though comments indicated that review of restraints as required by state policy was occurring. The monitoring team found that the facility did not yet have an adequate system in place for review of restraints. C1, C4, C5, C6, C7, and C8 were not yet in compliance. Even so, there had been considerable progress made in developing an adequate self-assessment process.
	Summary of Monitor's Assessment: DADS updated its restraint policy as of 4/10/12. The policy included new definitions for each type of restraint and set new guidelines for restraint debriefing and monitoring. The facility had reviewed the new policies and had begun implementing some of the requirements of the new policy, specifically, the new restraint checklists and monitoring guidelines. All requirements of the new policy had not yet been implemented, particularly in regards to protective mechanical restraints used for self-injurious behavior and medical restraint. The facility management stated that they found the new restraint policy requirements to be cumbersome and required additional staff to input data required to meet documentation requirements. The total number of restraints used for crisis intervention had increased since the previous monitoring visit. On a positive note, however, restraints for individuals with the highest number of restraint during the past monitoring visit had significantly decreased. This was attributed to a targeted focus on programming and treatment for those individuals. In order to move forward, the facility will need to expand this focus on individualized programming and treatment for all individuals at the facility. The facility should take a closer look at behavioral and restraint data to address factors that often lead to behavior that results in restraints. Some factors that were identified by the facility (e.g., in its restraint data in the trend analysis report) and by monitoring team's review of a sample of restraints include:

- Lack of individualized supports and treatment plans
- Individuals were frequently moved among cottages and dorms
- Inadequate staffing patterns
- Inadequately trained staff
- Staff scheduling issues
- Lack of attention to communication needs and supports.

Two major projects had been initiated at the facility during the past six months that may help to reduce the number of restraints. The first was a grant from the Hogg Foundation specifically aimed at reducing the number of behavioral incidents and restraints at the facility. The second involved consultation with a team of forensic experts to address service delivery and programming at the facility. Both projects were in the initial phases of implementation, so progress (and possible effects) could not yet be measured.

Based on information provided by the facility, there were 280 physical restraints used for crisis intervention between 3/1/12 and 8/31/12. Although the facility reported an overall decrease in the number of restraints from the previous year, this was an increase from the 255 physical restraints used for crisis intervention during the previous six-month reporting period.

Month	Total Restraints	Month	Total Restraints
September 2011	61	March 2012	64
October 2011	51	April 2012	45
November 2011	34	May 2012	55
December 2011	31	June 2012	30
January 2012	43	July 2012	44
February 2012	35	August 2012	42

Additionally, there had been five chemical restraints used for crisis intervention since 5/1/12.

The facility reported no incidents of pretreatment sedation prior to medical and dental appointments. This practice is further discussed in section J of this report.

At the time of the review, the facility staff reported that they had not yet addressed protective mechanical restraints to comply with the new statewide restraint policy. Protective Mechanical Restraint Plans had not been developed individuals who were wearing protective restraints due to self-injurious behaviors.

Following the onsite review, DADs reported that there were no protective mechanical restraints being used at the facility. The facility reported that IDTs determined that all mechanical restraints being used for self-injurious behavior were medical restraints. The facility will need to ensure that medical restraint plans have been developed for those restraints.

The facility had made good progress towards meeting compliance with requirements for documenting and

	reviewing restraint incidents for crisis intervention. The facility was in substantial compliance with one of the eight provision items (C2).

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The facility provided a list of all restraints used for crisis intervention between 3/1/12 and 8/30/12: • 285 restraints occurred. • 70 individuals were the subject of restraints. • Five individuals accounted for 44 restraints (21%). • 280 were personal hold restraints, and • 5 were chemical restraints. This was an increase from the 226 crisis intervention restraints reported at the last monitoring visit. There had been a significant decrease in the number of restraints for the two individuals with the highest number of restraints in the last sample. Staff attributed this decrease to individualized programming and consistent behavioral intervention for those two individuals. There were no instances of dental/medical pretreatment sedation reported by the facility since 3/1/12. The facility staff reported that they had recently begun to address protective mechanical and medical restraints to comply with the new statewide restraint policy. IDTs were just beginning to engage in adequate discussions that should result in determination that the restraint is the least restrictive restraint necessary and set specific guidelines for applying and monitoring the restraint. The IDT for Individual #151 held an interdisciplinary discussion regarding the continued need for his abdominal binder and mittens used to prevent him from removing his gastrointestinal tube and tracheostomy. The team gave serious consideration to the need for the restraint and developing strategies to reduce his time spent in restraint. This was a very positive step. The facility needs to continue to focus on protective mechanical restraints, including the development of strategies to reduce the amount of time in restraint, eliminate restraint when possible, and/or consider the use of the least restrictive restraint necessary. This includes looking at the use of gait belts, helmets, abdominal binders, and mittens.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Prone Restraint Based on the state and 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 list provided by the facility of all restraints for the past six months, 0 (0%) showed use of prone restraint. A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises. Sample #C.1 was a sample of 22 restraints for nine individuals, representing 8% of restraint records over the last six-month period. The sample included 19 physical restraints and three chemical restraints. Three of the individuals in the sample had the greatest number of restraints. Six others represented some of the most recent restraints. The individuals in this sample were Individual #56, Individual #365, Individual #436, Individual #441, Individual #63, Individual #483, Individual #589, and Individual #373. • Individual #56 and Individual #365 each had 16 restraints. • Individual #436 had 12 restraints. • These three individuals accounted for 15% of the 285 restraints for crisis intervention between 3/1/12 and 8/30/12. The new statewide restraint policy required that: • Restraints were not used unless necessary to prevent imminent physical harm in a behavioral crisis, to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior that has not yet been reduced by intensive supervision or treatment. • The least restrictive effective restraint necessary to prevent imminent physical harm in a behavioral crisis, or to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior was used. • Restraints were not used as punishment, as part of a positive behavior support plan, for staff convenience, or in the absence of or as an alternative to treatment. • Prone and supine restraints were prohibited. Other Restraint Requirements 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.	

#	Provision	Assessment of Status	Compliance
		Restraint records were reviewed for Sample #C.1 that included documentation for 22 restraints. The following are the results of this review: • In 22 of the 22 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • In 22 of 22 (100%) restraints, staff documented events leading to the behavior that resulted in restraints. • In 22 of 22 records (100%), staff documented that restraint was used only after other interventions had been attempted. State policies identified a list of approved restraints techniques. Based on the review of documentation for 22 restraints, 22 (100%) were documented as approved restraints techniques. <u>Dental/Medical Restraint</u> Data provided by the facility indicated that no pretreatment sedation had been administered prior to medical or dental appointments in the past six months. A list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that there were five desensitization plans in place. The facility was not yet in compliance with provision C1. To do so: • Individualized Crisis Intervention Plans should be developed for individuals who have had more than three restraints in a 30-day rolling period. • The long-term use of protective mechanical restraints should be reviewed by the IDT as per the new state regulations and strategies should be developed to reduce the amount of time in restraint, and/or eliminate the restraint when whenever possible. IDTs should consider the least restrictive type of restraint necessary to protect the individual from harm. • IDTs should focus on developing ISPs that support meaningful engagement throughout each individual's day.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The new statewide restraint policy required that any individual who is restrained as a result of a behavioral crisis must be released from restraint as soon as he or she no longer poses an imminent risk of physical harm to self or others. It further required that if a Crisis Intervention Plan is in place, the plan must describe the behaviors that signal there is no longer an imminent risk of physical harm to self or others. Safety Plans for Crisis Intervention (SPCIs) had been developed for the three individuals in the sample with the greatest number of restraints. SPCIs described behavioral	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		indicators that would signal that the individual was no longer a danger to himself or others. Crisis Intervention Plans (CIPs) to replace the SPCIs had not yet been developed for all individuals to comply with requirements of the new policy. CIPs developed in accordance with the new state policy were reviewed for Individual #309 and Individual #235. The new plans offered a much clearer guide for staff on what interventions to attempt prior to restraint, what behaviors would lead to restraint, and what behaviors indicated that the individual was no longer a risk of harm to himself or others. The facility self-assessment indicated a 90% compliance rating with the requirements for terminating restraint based on audit findings for March 2012 through July 2012. A review of four safety plans for the inclusion of release criteria found 100% compliance with this requirement. The facility self-assessment found substantial compliance with C2. The Sample #C.1 restraint documentation for 19 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. • 14 of 19 (74%) restraints reviewed indicated that the individual was released immediately when no longer a danger. The remaining five restraint checklists indicated that the individual was released because staff could not maintain the proper hold. • The longest physical restraint in the sample was 11 minutes for Individual #365 on 7/14/12. Ten (53%) of the physical restraints in the sample lasted two minutes or less. The facility was in substantial compliance with C2	
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	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 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 • 23 of 24 (96%) had current training in RES0105 Restraint Prevention and Rules. • 19 of the 23 (83%) employees with current training who had been employed	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	over one year completed the RES0105 refresher training within 12 months of the previous training. • 23 of 24 (96%) had completed PMAB training within the past 12 months. • 21 of the 23 (91%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. The facility self-assessment indicated a 100% compliance rating with the training requirements of C3. Based on this, the facility found substantial compliance with provision item C3. The monitoring team rated substantial compliance given that the percentages maintained high.	
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 22 restraint records (Sample #C.1), documentation in 22 (100%) indicated that restraint was used as a crisis intervention. Facility policy did not allow for the use of restraint for reasons other than crisis intervention, protection from self-injurious behaviors, or to complete medical/dental procedures. The facility indicated that no pretreatment sedation had been used for medical and/or dental treatment in the past six months. According to a list provided to the monitoring team, a written desensitization program had been developed for four individual since 12/27/11 that historically needed pretreatment sedation or restraint to have routine medical or dental care completed. The dental desensitization plans, written for four individuals, included individualized strategies to try to reduce the need for pretreatment sedation. The facility had created a "Do Not Restrain" list. There were 24 individuals at the facility 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. None of the individuals in the restraint sample appeared on the "Do Not Restrain" list. As noted in C1, the facility had begun to address the review requirements for all protective mechanical restraints. The facility should ensure that these protective restraints are documented, monitored, and reviewed. Teams should review all uses of protective mechanical restraints and document attempts at reducing the use of these restraints and ensuring that the least restrictive restraint necessary is being used. The facility had not begun to document the use of protective mechanical restraints used for self-injurious behavior to comply with the new statewide restraint policy. Forms to	Noncompliance

#	Provision	Assessment of Status	Compliance
		document the application of protective mechanical restraints and medical restraints had been developed in conjunction with the new policy. MSSLC had not yet implemented the new forms. Medical restraint plans had not yet been completed for individuals who were wearing protective restraints due to self-injurious behaviors. The facility was not yet in compliance with this provision item.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Review of facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. This training was competency-based. Based on a review of 22 crisis intervention restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 19 out of 22 incidents of restraint (86%), there was assessment by a restraint monitor. In the 19 instances of physical restraint in the sample, there was a face-to-face assessment form completed. The new restraint policy requires that the Face-to Face Assessment/Debriefing (FFAD) be used in all instances of restraint used for crisis intervention. An FFAD was not completed for the three chemical restraints in the sample. • The assessment began as soon as possible, but no later than 15 minutes from the start of the restraint in 18 (82%) out of 22 instances. The exceptions were: o The three chemical restraints and o The restraint for Individual #483 dated 8/27/12. The restraint monitor arrived 39 minutes after the restraint was initiated. Based on a review of 19 physical and three 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 (for a minimum of two hours with the use of chemical restraint) in 17 (77%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #63 dated 8/27/12 (late) o Individual #483 dated 8/27/12 (late) o Individual #589 dated 8/4/12 (incorrect frequency) o Individual #589 dated 6/9/12 (incorrect frequency) o Individual #373 dated 7/21/12 (incorrect frequency)	Noncompliance

#	Provision	Assessment of Status	Compliance
		Findings from the facility's self-assessment were similar to findings of the monitoring team in regards to post restraint assessment. The new statewide policy required that a nursing assessment occur within 15 minutes of the restraint initiation. The facility assigned a noncompliance rating to this provision item. The facility remained out of compliance with this provision. Monitoring by a nurse should be conducted and documented as required by state policy. All restraints should be immediately reviewed by a restraint monitor.	
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 22 Restraint Checklists for individuals in crisis restraint was selected for review for required elements in C6. The following compliance rates were identified for each of the required elements: • In 22 (100%), continuous one-to-one supervision was indicated as having been provided on the restraint checklist. • In 22 (100%), the date and time restraint was begun were indicated. • In 22 (100%), the location of the restraint was indicated. • In 22 of 22 (100%) restraints, staff documented events leading to the behavior that resulted in restraints. • In 22 (100%), the specific reasons for the use of the restraint were indicated. • In 21 (96%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. The exception was the restraint checklist for Individual #365 dated 7/29/12. • In 22 (100%), the names of staff who applied/administered the restraint was recorded. • In 22 (100%) of 22 observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In 19 (100%) of 19 physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 19 (86%) of 22 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. The exceptions were for Individual #365 dated 8/10/12, Individual #441 dated 8/28/12, and Individual #436 dated 8/10/12. • 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 11 minutes in duration. In a sample of 22 records (Sample C.1), FFADs had been completed for 19 (86%). These forms were generally complete in checking all the required boxes on the form, supplemented with appropriate narrative. The attention to detail required to complete	Noncompliance

#	Provision	Assessment of Status	Compliance
		this documentation accurately had improved since the last review. The facility had made significant progress in adequately documenting restraint incidents, however, remained out of compliance with the documentation requirements of C6. A FFAD should be completed for each instance of restraint and a nursing assessment for injury obtained during restraint should be completed.	
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, eight individuals were placed in restraint more than three times in a rolling 30-day period. This represented a decrease from the last two reviews when 11 and 17 individuals were placed in restraint more than three times in a rolling 30-day period. Three (i.e., Individual #56, Individual #436, and Individual #365) of these eight individuals (38%) were reviewed by the monitoring team to determine if the C7 requirements of the Settlement Agreement were met. PBSPs, crisis intervention plans, and individual support plan addendum (ISPA) meeting minutes that occurred as a result of more than three restraints in a rolling 30-day period were requested for each individual. The facility indicated that no ISPA meetings occurred for Individual #365 following more than three restraints in a 30-day period. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. This item was rated as being in noncompliance because not every individual who met criterion had documentation of a ISPA meeting following more than three restraints in a rolling 30-day period occurred, and the available ISPAs did not consistently reflect a discussion of each individual's adaptive skills and biological, medical, and psychosocial factors and an action plan for modifying them to prevent the future probability of restraint. One (Individual #56) of the two ISPA minutes reviewed (50%) reflected a discussion of adaptive skills, or biological, medical, or psychosocial factors affecting the behaviors provoking restraints. Individual #56's ISPA indicated that his Geodon medication was recently decreased and that he reported hearing voices prior to one of his aggressive outbursts that preceded restraint. No discussion, however, of possible action (e.g., referral to the psychiatrist, etc.) was documented in the ISPA.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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;	This item was rated as being in noncompliance because none of the ISPA meeting minutes reviewed included a discussion of possibly contributing environmental conditions. In order to achieve compliance with this provision item, each ISPA meeting minutes following more than three restraints in a rolling 30-day period should reflect a discussion of possible contributing environmental factors (e.g., noisy environments), 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. One (Individual #56) of the two ISPAs reviewed (50%) included a discussion indicating that the team hypothesized that attention from staff maintained Individual #56's physical aggression which provoked restraint. Individual #56's ISPA minutes, however, did not reflect a discussion of potential action to address this hypothesis (e.g., increasing staff attention when Individual #56 was engaging in desired behavior). In order to achieve compliance with this provision item, the ISPA should reflect a discussion of the variables maintaining the dangerous behavior (e.g., staff attention) that provokes restraint. The ISPA minutes should also reflect an action (e.g., increase staff attention for appropriate behaviors, etc.) to address this potential source of motivation for the target behavior that provokes restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(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 three of the individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Three (100%) were based on the individual's strengths, • Three (100%) of the PBSPs reviewed specified the objectively defined behavior to be treated that led to the use of the restraint (see K9 for a discussion of operational definitions of target behaviors), • Two (Individual #365 and Individual #56) of the three PBSPs reviewed (67%) specified the alternative, positive, and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, and • All three of the PBSPs (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. Two of these three PBSPs (67%), designed to weaken or reduce the behaviors that provoked restraint, however, were determined to be incomplete (i.e., Individual #56, Individual #436) because they did not contain clear, precise interventions based on a functional assessment (see K9). All three crisis intervention plans in the sample were reviewed. The following represents the results: • In all three crisis intervention plans reviewed (100%), the type of restraint authorized was delineated, • In one (Individual #365) crisis intervention plan reviewed (33%), the maximum duration of restraint authorized was specified, • In all three plans reviewed (100%), the designated approved restraint situation was specified, and • In all three crisis intervention plans reviewed (100%), the criteria for terminating the use of the restraint were 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

#	Provision	Assessment of Status	Compliance
	(g) as necessary, assess and revise the PBSP.	There was evidence that one PBSP (i.e., Individual #436) was modified when necessary to address a lack of progress (see K4 for details), though not in response to the review as required by this provision item. Additionally, Individual #56's ISPA indicated that his PBSP was evaluated and it was determined that no changes were necessary. There was no evidence, however, that Individual #365's PBSPs was reviewed and/or modified after the review required by this provision item, to decrease the future probability of him requiring restraint. In order to achieve substantial compliance with this provision item, all individuals who were placed in restraint more than three times in a rolling 30-day period, should have evidence of a review (in the ISPA), and revision when necessary, of the PBSP.	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.	According to policy, the review of each incident of restraint began with a FFAD completed by a restraint monitor immediately following the restraint. The restraint was then reviewed at the daily Unit Meeting and the daily Incident Management Team meeting, within three business days. During the onsite monitoring visit, Unit Meetings and Incident Management Team meetings were observed and, during this timeframe, discussion of restraint was evident on the day after the episode. At the unit level, the review consisted of some discussion regarding precursors to the incident and staff action taken during the restraint, along with a review of documentation. Preliminary recommendations were made and referred to the IDTs for follow up. The review by the IMT led to less discussion but appeared to be useful for informing management about the incident. In most instances, the restraint was also reviewed by the IDT within 24 hours of the incident. Follow-up to some restraint episodes was tracked through the use of a Special Restraint Review Tracking Log. Fourteen restraints had undergone a more in-depth review (including video review) to ascertain if restraint protocols were followed. For the 22 restraints in sample C1, • 19 of 22 (86%) were reviewed immediately by a restraint monitor. The exceptions were the three chemical restraint checklists in the sample. • 22 of 22 (100%) were signed by the unit director indicating review within three days. • 18 of 22 (82%) were signed by the IMT designee indicating review within three days. Exceptions were the physical restraint for Individual #365 dated 8/10/12 and the three chemical restraints in the sample.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Three of three (100%) chemical restraints were reviewed by the psychologist and psychiatrist within three days. It was not evident that errors in restraint methods or documentation always resulted in action taken to correct the problem. For example, three of the six restraints in the sample for Individual #56 were released because staff could not maintain an acceptable hold. There was no indication that this problem was reviewed and addressed by the IDT. The facility should ensure that the use of mechanical protective restraints are documented, monitored, and reviewed in accordance with the new state policy. Teams should review all uses of protective mechanical restraints and document attempts at reducing the use of these restraints and ensuring that the least restrictive restraint necessary is being used. The Restraint Review Committee (RRC) met regularly and reviewed restraint trends. The monitoring team observed an RRC meeting while onsite. Committee members analyzed data presented and discussed possible action to reduce any trends identified. Although there had been progress made in terms of ensuring that restraint reviews were documented, the facility was not yet in substantial compliance with this provision item. Review of crisis intervention restraints by a restraint monitor should be documented in all instances. ISPs should document discussion regarding the use of protective mechanical restraints for self-injurious behavior to include a schedule for monitoring, release, and reduction or elimination when considered clinically justifiable.	

Recommendations:

1. Address factors that contributed to behavior leading to restraint at the facility (C1).

2. The long-term use of protective mechanical restraints should be reviewed by the IDT as per the new state regulations and strategies should be developed to reduce the amount of time in restraint, and/or eliminate the restraint when necessary. IDTs should consider the least restrictive type of restraint necessary to protect the individual from harm (C1, C2, C4, C8).

3. Develop individualized Crisis Intervention Plans for individuals who have had more than three restraints in a 30-day rolling period to meet criteria in the state policy (C1).

4. Ensure all staff receive training annually on the use of restraint and positive behavioral interventions (C3).

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

6. All restraints should be immediately reviewed by a restraint monitor (C5).

7. All restraints should be documented consistent with Appendix A (C6).

8. Each individual's ISPA meeting minutes following more than three restraints in 30 days should reflect a discussion of each of the issues presented in C7, and a plan to address factors that are hypothesized to affect the use of restraints. Additionally, there should be evidence that each individual's PBSP has been implemented with integrity, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent) (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 Preventing Abuse, Neglect, Exploitation training curriculum dated April 2012 o Information used to educate individuals/LARs 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 Training transcripts for 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Training and background checks for the last three employees hired o Training transcripts for DFPS investigators assigned to complete investigations at MSSLC o Abuse/Neglect/Exploitation Trend Reports FY12 o Injury Trend Reports FY12 o List of incidents for which the reporter was known to be the individual or their LAR 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 #446, Individual #436, Individual #451, Individual #325, Individual #287, and Individual #157 o Injury reports for three most recent incidents of peer-to-peer aggression incidents o ISP, PBSP, 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 ANE allegations since 3/1/12 including case disposition o List of all investigations completed by the facility since 3/1/12 o List of employees reassigned due to ANE allegations o Documentation of employee disciplinary action taken with regards to the last three incidents of confirmed abuse or neglect.

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

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#42416502	Sexual Abuse (2)	Unfounded	8/12/12 7:45 am	8/12/12 3:11 pm	8/16/12
#42183992	Neglect (3)	Unconfirmed (2) Confirmed (1)	5/26/12 3:54 am	5/27/12 12:37 pm	6/13/12
#42320156	Neglect	Confirmed	6/11/12 11:55 am	6/11/12 3:30 pm	6/21/12
#42005432	Neglect	Confirmed	5/7/12 12:59 pm	5/8/12 3:28 pm	5/17/12
#42363569	Physical Abuse	Confirmed	7/4/12 1:59 pm	7/5/12 1:20 pm	7/24/12
#42366483	Neglect Physical Abuse	Confirmed Unconfirmed	7/6/12 12:29 pm	7/6/12 8:45 pm	7/25/12
#42367669	Physical Abuse	Unconfirmed	7/7/12 5:25 pm	7/8/12 12:15 pm	7/16/12
#42382944	Neglect (2)	Confirmed (2)	7/19/12 9:40 am	7/19/12 6:51 pm	7/29/12
#42389693	Emotional Verbal Abuse	Unconfirmed	7/24/12 12:53 pm	7/24/12 3:27 pm	8/1/12
#42401304	Neglect (2)	Unconfirmed (2)	8/1/12 8:37 pm	8/4/12 4:20 pm	8/11/12
#42402152	Emotional Verbal Abuse	Unfounded	8/2/12 1:14 pm	8/2/12 4:00 pm	8/7/12
#42404595	Emotional Verbal Abuse Physical Abuse	Unconfirmed Unconfirmed	8/4/12 9:08 am	8/5/12 12:59 pm	8/21/12
#42409800	Physical Abuse (7)	Unfounded (7)	8/8/12 1:16 am	8/11/12 8:00 am	8/15/12
#42415597	Physical Abuse	Unconfirmed	8/10/12 5:56 pm	8/10/12 7:34 pm	8/24/12
#42419355	Physical Abuse (2)	Unconfirmed (2)	8/14/12 10:15 am	8/16/12 7:08 am	8/29/12
#42421628	Physical Abuse	Unconfirmed	8/15/12 11:46 am	8/16/12 2:56 pm	8/23/12
#42427024	Neglect	Unfounded	8/18/12 10:36 pm	8/19/12 11:14 pm	8/28/12

Sample D.2	Type of Incident	DFPS Disposition	Date of DFPS Referral	DFPS Completed Investigation	Facility Completed Investigation
#42429061	Neglect	Referred Back – Training Issue	8/20/12	8/24/12	9/6/12
#42421641	Physical Abuse	Referred Back – Admin Issue	8/15/12	8/25/12	9/6/12
#42434531	Neglect	Referred Back – Admin Issue	8/23/12	8/24/12	9/6/12
#42404708	Neglect	Referred Back-Admin Issue	8/3/12	8/7/12	8/7/12
#42195213	Neglect	Referred Back-Admin Issue	5/27/12	5/27/12	6/11/12

Sample D.3	Type of Incident	Date/Time of Incident Reported	Director Notification		
#965	Serious Injury	6/10/12 10:12 am	6/10/12 10:25 am		
#1060	Unauthorized Departure	7/11/12 9:45 am	7/11/12 9:45 am		
#1119	Serious Injury – Peer to Peer Aggression	7/28/12 8:30 pm	7/28/12 8:57 pm		
#1101	Serious Injury	7/23/12 3:20 pm	7/23/12 3:28 pm		
#1141	Serious Injury Suicide Threat	8/6/12 11:44 am	8/6/12 11:52 am		
#1186	Suicide Threat	8/17/12 6:34 pm	8/17/12 6:55 pm		
#1276	Serious Injury	9/16/12 9:49 am	9/16/12 10:24 am		

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
- Alynn Mitchell, Acting QDDP Coordinator
- Joy Lovelace, Human Rights Officer

	Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 9/24/12 and 9/26/12 o ISP preparation meeting for Individual #94 o Annual IDT Meeting for Individual #151 o Shamrock PIT Meeting 9/26/12 o Longhorn PIT Meeting 9/27/12 o Restraint Reduction Committee Meeting 9/27/12 o Quarterly QA/QI Meeting
	Facility Self-Assessment: MSSLC submitted its self-assessment. It was updated on 9/6/12. Along with the self-assessment, the facility had two others documents that addressed progress towards meeting requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement and one 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 similar activities implemented by the monitoring team to assess compliance. For example, for D2f, the facility reviewed monthly monitoring reports completed by Campus Administrators to assure that rights posters were present, visible, and readable. Additionally, random visits were made in homes and day programs to look for postings. The facility was using the statewide section D audit tool, supplemented by additional activities for each provision item. The facility's review of its own performance found compliance with all provisions of section D. The monitoring team also found the facility to be in substantial compliance with 19 of the 22 provision items. The monitoring team did not find compliance with the requirements of review and follow-up to investigations (D3g and D3i) or with the requirement to address trends (D4). Trend reports should be used to analyze whether or not compliance with section D requirements has an impact on the number of incidents and injuries at the facility. Ultimately, a reduction in these numbers should be a result of improvements in the incident management system.

	Summary of Monitor's Assessment: According to a list provided by MSSLC, DFPS conducted investigations of 2208 allegations at the facility since March 2012, involving 743 allegations of physical abuse, 427 allegations of sexual abuse, 574 allegations of verbal/emotional abuse, 13 allegations of exploitation, and 451 allegations of neglect. Of the 2208 allegations, there were 17 confirmed cases of physical abuse, 1 confirmed case of sexual abuse, 4 confirmed cases of verbal/emotional abuse, and 48 confirmed cases of neglect. An additional 108 other serious incidents were investigated by the facility. There were a total of 576 injuries reported in the quarter between 6/1/12 and 8/31/12. These 576 injuries included 18 serious injuries resulting in fractures or sutures. The facility needs to aggressively address trends in injuries and implement protections to reduce these incidents and injuries. Although the facility reported a 2% decrease in the number of serious incident since the last monitoring visit, the number of confirmed allegations of abuse, neglect, and exploitation had increased from 32 confirmed allegations to 70 confirmed allegations. It is likely that, in part, this increase could be attributed to better reporting and investigation procedures. However, there continued to be a high number of unusual incidents occurring at the facility, which might have been avoided with adequate protections in place. Some positive steps taken to address the provision items of section D included: • The tracking system for investigation and follow-up had been improved. • New "Zero Tolerance" posters related to abuse, neglect, and retaliation were placed throughout the facility. • A/N/E trends were now being presented at quarterly QAQI Council meetings and monthly unit meetings. • The Employee Reassignment Center (ERC) had been restructured to operate 24 hours a day/7 days a week to allow alleged perpetrators to work their regular shift. This also allowed DFPS investigators to set up more timely interviews with APs. Recommendations resulting from investigations, incidents, and injuries should include a focus on systemic issues that are identified and action steps should be developed to address those issues. According to data gathered by the facility, some systemic issues that contributed to a large number of incidents and injuries at MSSLC included: • Behavioral issues, • Staffing patterns, • Lack of adequate supervision, • Frequent moves among homes at the facility, • Failure to carry out support plans as written, • Lack of adequate individualized planning and supports, and • Communication issues

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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. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report.	Substantial Compliance
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	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.	Substantial Compliance

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	Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	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, investigations of 2208 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility between 3/1/12 and 8/31/12. From these 2208 allegations, there were: • 743 allegations of physical abuse: o 17 were confirmed, o 360 were unconfirmed, o 302 were unfounded, o 13 were inconclusive, o 21 were referred back to the facility for further investigation, and o 28 outcomes were pending. • 147 allegations of sexual abuse: o 1 was confirmed, o 14 were unconfirmed, o 110 were unfounded, o 12 were referred back to the facility for further investigation, and o 9 outcomes were pending. • 574 allegations of verbal/emotional abuse: o 4 were confirmed, o 204 were unconfirmed, o 145 were unfounded, o 7 were inconclusive, o 57 were referred back to the facility for further investigation, and o 9 outcomes were pending. • 450 allegations of neglect: o 48 were confirmed, o 198 were unconfirmed, o 14 were inconclusive, o 70 were unfounded, o 102 were referred back to the facility for further investigation, o 16 outcome was pending, and o 2 other.	

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		• 13 allegations of exploitation:
		  o 7 were unconfirmed,
		  o 2 were inconclusive, and
		  o 4 were referred back to the facility for further investigation.
		
		The facility reported that there were 108 other investigations of serious incidents not involving abuse, neglect, or exploitation between 3/1/12 and 8/31/12. This included:
		• 22 serious injuries/determined cause
		• 6 serious injuries/peer-to-peer aggression,
		• 6 serious injuries/client offenders,
		• 2 serious injuries/undetermined cause,
		• 2 sexual incidents,
		• 7 sexual incidents/offenders,
		• 1 choking incident,
		• 11 unauthorized departures,
		• 11 suicide threats,
		• 6 encounters with law enforcement,
		• 22 serious injuries, and
		• 36 other unclassified serious incidents.
		
		From all investigations since 3/1/12 reported by the facility, 29 investigations were selected for review. The 29 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 (17 cases).
		• Sample #D.2 included a sample of facility investigations that had been referred to the facility by DFPS for further investigation (5 cases).
		• Sample #D.3 included investigations the facility completed related to serious incidents not reportable to DFPS (7 cases).
		
		Based on a review of the 17 investigative reports included in Sample #D.1:
		• 17 of 17 reports in the sample (100%) indicated that DFPS was notified within one hour of the incident or discovery of the incident.
		• 17 of 17 (100%) indicated the facility director or designee was notified within one hour by DFPS.
		• 17 of 17 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate.
		• 16 of 17 (94%) documented that the state office was notified as required. The exception was DFPS case #42382944.	

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		In reviewing Sample D.3 (serious incidents), documentation indicated: • Six of seven (86%) were reported immediately (within one hour) to the facility director/designee. UIR#1060 involved an unauthorized departure from campus that was not reported until the following morning. • Documentation of state office notification, as required by state policy, was found in six of six (100%) UIRs. 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 that contained information about notifications was included in: • 17 out of 17 (100%) investigation files in Sample #D.1. • 12 of 12 (100%) investigation files in Sample #D.2 and Sample #D.3. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. All employees signed an acknowledgement form annually. A sample of this form was a random sample of 24 employees at the facility. All employees (100%) in the sample had signed this form. The facility was in substantial compliance with the requirements of D2a.	
	(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 policy 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 17 investigation reports included in Sample D.1, in 16 out of 17 cases (94%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status. In DFPS case #42416502, the alleged victim was on the spurious allegation list. The AP was placed under a higher level of supervision. The monitoring team was provided with a log of employees who had been reassigned since 3/1/12. The log included the applicable investigation case number and the date the employee was returned to work. All allegations were discussed in the daily IMRT meeting and protections were monitored through meeting minutes for each open investigation. In 17 out of 17 cases (100%), there was no evidence that the employee was returned to	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		his or her previous position 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 17 investigation files in Sample D.1, 17 (100%) UIRs documented additional protections implemented following the incident. This typically consisted of placing the AP in a position of no client contact, and a head-to-toe assessment by a nurse. The facility was in substantial compliance with this provision.	
	(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. A random sample of training transcripts for 24 employees was reviewed for compliance with training requirements. This included two employees hired within the past year. • 23 (96%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 20 (95%) of 21 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. • 23 (96%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 19 (90%) of the 21 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. The facility was in substantial compliance with this provision.	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	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 after completing ABU0100 training. A sample of this form was reviewed for a random sample of 24 employees at the facility. All employees (100%) in the sample had a current signed acknowledgement form.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility reported that there were no cases where employees failed to report abuse, neglect, or exploitation or did not cooperate with investigators during an investigation in the past six months. The monitoring team assigned a substantial compliance rating to this provision.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. It was a clear and easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. A sample of six ISPs developed after 3/1/12 was reviewed for compliance with this provision. The sample ISPs were for Individual #446, Individual #436, Individual #451, Individual #325, Individual #287, and Individual #157. • Six (100%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The new ISP format included a review of all incidents and allegations along with a summary of that review. This should be useful to teams in identifying trends and developing individual specific strategies to protect individuals from harm. 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. Most individuals named a staff member that they were comfortable telling they had a problem. Allegations were routinely self-reported by the individuals at the facility indicating that at least some individuals at the facility knew how to report abuse or neglect to DFPS. The facility was in substantial compliance with this item.	Substantial Compliance

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	(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. A poster inventory checklist was created to ensure ANE information and rights posters were in place in all buildings. Campus administrators were assigned responsibility for ensuring posters remained in place. There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with her name, picture, and contact information. The facility remained in substantial compliance with this provision item.	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 17 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and OIG of the allegation in all (100%), as appropriate. The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's	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 by stating that any employee or individual who in good faith reports abuse, neglect, or exploitation shall not be subjected to retaliatory action by any employee of MSSLC. • 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 no cases where fear of retaliation was reported. Based on a review of	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	failure to report an incident in an appropriate or timely manner.	investigation records (Sample #D.1), there were no other 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.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Staff were required to notify the facility director and DFPS of injuries of unknown origin where probable cause cannot be determined and to DADS Regulatory if the injury was deemed serious. The facility: • Reviewed all injuries, including injuries at the Unit Team meeting daily to discuss probable cause and develop corrective action. • Quarterly data reports were used to identify trends in injuries. • The Risk Manager completed 10 audits quarterly of non-serious injuries quarterly. Sample #D3 included investigations completed on a sample of five serious injuries. All five investigations were thorough and completed using a standardized UIR. The facility incident tracking log noted one serious injury (for Individual #225 on 6/3/12) that was not reported immediately by the physician. Corrective action was taken to ensure that the physician was aware of reporting requirements. Based on observations and the sample of documentation reviewed, the facility's audit system was adequate for ensuring that injuries or trends of injuries were reported for investigation. The facility remained in substantial compliance with this provision item.	Substantial Compliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		

#	Provision	Assessment of Status	Compliance
	(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. Fourteen DFPS investigators were assigned to complete investigations at MSSLC. The training records for DFPS investigators were reviewed with the following results: • Thirteen investigators (100%) had completed the requirements for investigations training. • Thirteen DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. MSSLC had nine employees designated to complete investigations. There had been no changes in the investigation team since the last review. All facility investigators were fully trained. 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 remained in substantial compliance with this item.	Substantial Compliance
	(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 staff did not cooperate with any outside agency conducting investigations.	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 17 investigations completed by DFPS (Sample #D.1), 13 had been reported to law enforcement agencies. OIG investigated five of the incidents. In	Substantial Compliance

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		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.	
	(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. 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 with the alleged victim occurred within 24 hours in 13 of 17 (76%) investigations. In all but one case (DFPS #42401304) where the interview did not occur within 24 hours, an interview with the alleged victim occurred the following day. o Seventeen (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. This included gathering documentary evidence and making initial contact with the facility. • Eleven of 17 (65%) were completed within 10 calendar days of the incident. Extensions were filed in the six of six cases (100%) that were not completed within 10 calendar days. In four of the six cases that took longer than 10 days to	Substantial Compliance

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		complete, OIG was also conducting an investigation. The lengthiest investigation in the sample was DFPS #42363569, which was completed in 20 days. A physical abuse allegation was confirmed. Although the investigation noted that an extension had been filed on the 10th day, the extension was not included in the investigation packet, so reason for the extension was unknown to the monitoring team. • The facility incident management team continued to work closely with DFPS to facilitate timely completion of investigations. Changes had been made to the employee reassignment process to ensure that staff were more readily available for interviews with investigators, since this had been identified as a delay in a number of cases. • All 17 (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 15 of the 22 (68%) DFPS investigations reviewed in Sample #D.1 and #D.2, concerns or recommendations for corrective action were included. Five of those cases resulted in referrals back to the facility for further investigation. 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 : • UIRs reviewed did not indicate when the investigation began, but most were completed within 24 hours indicating that the investigation began within 24 hours. • Seven of seven (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Five of seven investigations included recommendations for corrective action. The facility completed facility investigations and follow-up on DFPS investigations in a timely manner.	
	(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	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.	Substantial Compliance

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	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.	<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 17 (100%), each serious incident or allegations of wrongdoing;
		o In 17 (100%), the name(s) of all witnesses;
		o In 17 (100%), the name(s) of all alleged victims and perpetrators (when known);
		o In 17 (100%), the names of all persons interviewed during the investigation;
		o In 17 (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 17 (100%), all documents reviewed during the investigation;
		o DFPS investigations now included a statement indicating that previous investigations were reviewed and either found relevant or not relevant to the case.
		o In 17 (100%), the investigator's findings; and
		o In 17 (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 seven (100%), each serious incident or allegations of wrongdoing;
		o In seven (100%), the name(s) of all witnesses;
		o In seven (100%), the name(s) of all alleged victims and perpetrators when known;
		o In seven (100%), the names of all persons interviewed during the investigation;
		o In seven (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 seven (100%), all documents reviewed during the investigation;
		o In seven (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim known to the investigating agency.
		o In seven (100%), the investigator's findings; and
		o In seven (100%), the investigator's reasons for his/her conclusions.	

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		The facility was in substantial compliance with this item, however, DFPS will need to follow through with including a summary regarding previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency.	
	(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 16 DFPS investigations included in Sample #D.1 and #D.2: • In 17 (100%) investigative files reviewed from Sample #D.1 and #D.2, 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 Sample #D.1, • 16 (94%) DFPS investigations were reviewed by both the facility director and IMC following completion. DFPS #42005432 was not signed off on by the IMC or Director/Designee. • 10 of 17 (59%) were reviewed by the facility director and Incident Management Coordinator within five working days of receipt of the completed investigation. The exceptions were: o DFPS #42382944. The case was completed on 7/29/12 and signed off on by the IMC and Director designee on 8/9/12. There was a notation on the review form that the completed case was not received by the facility until 8/8/12. o DFPS #42367669 was completed on 7/16/12 and reviewed by the IMC and Director designee on 7/27/12. There was a notation on the review form that the completed case was not received by the facility until 7/26/12. o DFPS case #42366483 was completed on 7/25/12 and reviewed by the IMC and Director designee on 8/9/12. o DFPS case #42363589 was completed on 7/24/12 and reviewed by the IMC and Director designee on 8/8/12. o DFPS case #42320156 was completed on 6/21/12 and reviewed by the IMC and Director designee on 7/9/12. o DFPS case #42416502 was completed on 8/16/12 and reviewed by the	Noncompliance

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		IMC and Director designee on 8/24/12. DFPS noted concerns or made recommendations in 10 (58%) of the cases in sample #D.1. The facility maintained documentation of follow-up action taken to address concerns and recommendations. See D3i for comments on follow-up to specific recommendations. Sample #D.2 included five investigations that were referred back to the facility for further review. • DFPS Case #42429061 was referred back to the facility as an administration issue. The file included a notification to the director of psychology regarding review of a BSP and to the unit director regarding staffing issues. Documentation was not included to show that either recommendation resulted in action taken by the facility. • DFPS case #4242164 was referred back to the facility as a right's issue. The alleged victim reported that he was locked in his room and not allowed to eat. DFPS determined that the allegation was unfounded. It was not clear what issue was being referred back to the facility for follow-up. The facility did not make any recommendations in the case. • DFPS case #42434531 was referred back to the facility for follow-up after DFPS ruled out neglect. The facility followed up with disciplinary action for staff not following the alleged victim's PNMP. Disciplinary action was documented in the investigation file. • DFPS case #42404108 was referred back to the facility as not meeting the definition of abuse or neglect. The facility investigated the incident further and determined that the allegation was unfounded. • DFPS case #42195213 was referred back to the facility as not meeting the definition of abuse or neglect. The facility followed up with disciplinary action for a staff member found sleeping on duty. Two daily review meetings (IMRT) were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily IMRT meetings. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> • In seven of seven (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 within five working days of completion.	

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		• Five of seven UIRs included recommendation for follow-up. Documentation of follow-up was included in all of the investigative records. Substantial compliance had not been met with the requirement for a timely review of completed DFPS investigations.	
	(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 29 out of 29 (100%) unusual incidents in the sample. A 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 the sample. Six of 17 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 five of six cases where allegations were confirmed. In the remaining case, the facility was found neglectful due to staffing issues. Staff were retrained on what to do if a similar incident occurred. DFPS noted concerns or made recommendations in 10 (58%) of the cases in sample #D.1. The facility maintained documentation of follow-up action taken to address concerns and recommendations. • Documentation of follow-up to all DFPS concerns was found in six (60%) of the investigation files in the sample. • Three of the cases noted concerns regarding the lack of cameras outside where the incidents occurred. There was no documentation found that addressed this concern. • In DFPS case #42401304 an individual at the facility received a serious injury during sexual intercourse with another individual. The alleged victim's sister stated that she was upset over the incident and wanted her sister to come live with her when she was informed of the incident. She stated that she felt like her sister should be monitored more closely and that just because she had mental retardation did not make it right for men to have sex with her. She was told that the IDT would meet to discuss this. The sister stated that she wanted to be present at the meeting. There was no evidence that the team met with the sister to discuss a possible move from the facility. There was also no evidence that STD testing was done on either individual following the incident. Neglect allegations were not confirmed in the case, since both individuals involved were on routine supervision.	Noncompliance

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		• DFPS case #42183992 involved a confirmed allegation of neglect following a sexual incident between two individuals. The neglect allegation was confirmed because staff failed to provide appropriate supervision. The facility UIR did not include any recommendations for follow-up action. One of the individuals involved had a history of inappropriate sexual behavior, including victimizing peers that were lower functioning, yet he had been moved into a home where lower functioning individuals resided. The other individual involved was described by staff as passive. The team met following the incident and agreed that he should be moved into another home. At the time of the review, the level of supervision had been decreased for both individuals and they were now roommates. Following the onsite review, the facility reported to the monitoring team that additional supervision was being provided until a change in housing could be made. Recommendations for programmatic actions were made in five of seven cases reviewed for facility investigations in Sample #D.3. Follow-up action was documented in four of five cases. UIR #1060 included a recommendation to review the facility policy on two-hour bed checks for individuals on routine supervision following an incident where an individual left campus. There was no documentation that the recommendation was addressed by the facility. The facility was not yet following up on all recommendations, documenting all follow-up action, and monitoring outcomes of the action. See D4 for additional comments regarding follow-up on trends identified in regards to incidents at the facility. The facility was not in substantial compliance with this item.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team.	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 had recently implemented the new statewide system to collect data on unusual incidents and investigations. Data were collected through the incident reporting system and trended by 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 the investigation. The facility had initiated a new process of compiling data on a quarterly basis for allegations of abuse, neglect, mistreatment, and other unusual incidents and injuries. Trends were reviewed in quarterly QAQI Council meetings and monthly in unit PIT meetings. Observation of both the quarterly QAQI Council meeting and two unit PIT meetings confirmed that data regarding unusual incident trends were being presented at meetings, however, it was not apparent that presentation of data led to action to resolve issues. Trend reports were up-to-date and included an analysis of the data gathered by the facility. Recommendations for action to address trends were not included in the trend reports. There was no evidence that the facility had developed a plan of correction to address systemic issues identified in trend reports. 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 data and frequently evaluate how data can best be used to evaluate progress and take action to reduce the significant number of incidents and injuries. The monitoring team expects to see the incident management department take a role in the facility's overall approach to addressing the frequency of occurrence of unusual incidents and injuries at MSSLC. They should help to determine and address factors that contributed to incidents and injuries at the facility.	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	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	Substantial Compliance

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	volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	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 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 FY12, criminal background checks were submitted for 899 applicants. There were a total of 11 applicants who failed the background check in the hiring process and therefore were not hired. 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 17 of 27 employees (71%). The facility remained in substantial compliance with this provision item. The facility needs to ensure that all employees have a signed acknowledgement to self- report criminal activities.	

Recommendations:

1. The facility will need to continue work with DFPS to ensure that all investigations are completed within 10 days unless there are extraordinary circumstances (D3e).

2. DFPS investigations should include a summary regarding previous investigations of serious incidents involving the alleged victim(s) and alleged perpetrator(s) known to the investigating agency and whether or not that information was relevant to the current investigation (D3f).

3. All completed investigations should be reviewed by the IMC and Director/designee and any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly (D3g).

4. Recommendations resulting from investigations, incidents, and injuries should include a focus on systemic issues that are identified and action steps should be developed to address those issues (D3g).

5. 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 (D3i).

6. 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 are accurate and how data can best be used to evaluate that progress (D4).

7. The facility needs to ensure that all employees have signed an acknowledgement to self-report criminal activities (D5).

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 MSSLC facility-specific policies: • Three were slightly revised: Quality Assurance 4/1/12, Participating in PIT Monthly Meeting 4/25/12, and Participating in PET Monthly Meeting 4/25/12 o Email from DADS assistant commissioner describing the formation of the statewide SSLC leadership council, 3/5/12 o Draft Section E self-assessment tool from state office, revised draft July 2012 (though page one was still dated April 2012) o MSSLC-completed draft section E self-assessment tools, July 2012 and August 2012 (two) o MSSLC organizational chart, 9/1/12 o MSSLC policy lists, August 2012 o List of typical meetings that occurred at MSSLC, undated, likely August 2012 o MSSLC Self-Assessment, 9/6/12 o MSSLC Action Plans, 9/6/12 o MSSLC Provision Action Information, most recent entries 8/7/12 o MSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/24/12 o MSSLC DADS regulatory review reports, 3/1/12 through 8/30/12, no annual survey o List of all QA department staff and their assigned responsibilities, undated o MSSLC QA department meeting notes, monthly, 3/16/12 through 8/16/12 (6 meetings) o Training on inter rater reliability, July 2012, 18 attendees o MSSLC data listing/inventory, hard copy and electronic copy, undated o MSSLC QA plan narrative, two similar versions, both undated o MSSLC QA plan matrix, two similar versions, both undated o Set of blank tools used by QA department staff (1 tool) • Completed tools done by six QA staff, June 2012 through August 2012 • Graphed and tabled data from these observations, through August 2012 • QA Monitor Tool Trend report, presented to QAQI Council, August 2012 o Trend analysis reports, various pieces, no complete report with all four components o Various packets of data and/or reports • DADS regulatory - Visit log, December 2011 through September 2012 - DADS regulatory tag tracking log • QA review meeting for follow-up to QA critical incident meetings, two pages, 3/15/12 to 5/10/12 • Incident Management Review Team:

	- End of month report of tracking of Incident Management Review Team recommendations, May 2012 to August 2012 - Completed IMRT recommendations, tracking instrument, 29 pages, 8/3/05 (sic) - Open IMRT recommendations, tracking instrument • Enteral feeding tube replacement data, 8/21/12 • Internal medical management audits, round 5, 7/16/12 (2 pages) • FSPI, two indicators, FY12 • Retail food establishment inspection report, 6/28/12 (1 page) o MSSLC QA Reports, monthly, June 2012 through August 2012 (3) o Executive Management Team, handout for 9/25/12 meeting o PIT meeting handout for Shamrock, 9/25/12 o PIT meeting minutes and data sets for each unit for past six months, March 2012 to August 2012 o PET IV meeting handout for 9/26/12 o PET meeting minutes for each PET group for past six months, March 2012 to August 2012 o QAQI Council meeting handout for 9/27/12 o QAQI Council minutes, 3/16/12 to 8/16/12, 10 meetings o MSSLC Corrective Action Plan, tracking, 3 pages of active CAPs from time of last review, 6 pages of 3 new CAPs since the last review o RN meeting agenda that includes topic of allergies CAP, 8/17/12 o MSSLC suggestion box summary table, along with a graph 2010 to present o DADS SSLC family satisfaction survey online summary, 4/12 through 7/12, 24 respondents o List of self-advocacy leadership 2012 o Self-advocacy monthly meeting minutes/notes, monthly 4/24/12 to August 2012, 3 meetings o Notes about other self-advocacy group activities since March 2012 o Home meeting agenda and notes, last two from each home, August 2012 o Facility newsletters, The Family Press, April 2012 through October 2012 (3); and Focus, March 2012 through August 2012 (6) <u>Interviews and Meetings Held</u>: o Kim Kirgan, Director of Quality Assurance o Etta Jenkins, Settlement Agreement Coordinator o Stormy Kimbriel, Donna Patterson, QA Department staff o Mike Davis, Facility Director o Bertha Allen, John Parks, Troy Miller, Polly Bumpers, Rodney Price, Residential Unit Directors o Joy Lovelace, Human Rights Officer <u>Observations Conducted</u>: o PIT meeting: Shamrock, 9/26/12 o PET IV meeting, 9/26/12 o QAQI Council meeting, 9/27/12 o Executive Management meeting, 9/25/12 o Self-advocacy meeting, 9/25/12

	o Chesapeake Consultants session with various staff in chapel, 9/26/12 o Don Morton's Pilot Group, 9/27/12
	Facility Self-Assessment The QA director improved upon the previous self-assessment by including additional activities and outcomes. Further, she took steps to include in her self-assessment some of the processes and outcomes that the monitoring team looks at. Much more work, however, will be needed. To further complicate matters, the QA director implemented her own self-assessment activities (i.e., the self-assessment given to the monitoring team) and she also implemented (twice) the state's draft proposed section E self-monitoring tool. The state tool was a reasonable attempt to list the requirements for substantial compliance. It did not, however, include all of what the monitoring team monitors. Further, the tool should not only indicate the presence of an activity or outcome, but the quality of it, too. For example, the tool asked if a data list inventory was completed, current, clear, and concise. The QA director rated these as yes, however, the monitoring team did not find this to be the case as noted in E1 below. One way to further improve the self-assessment is to go through the monitoring team's report, paragraph by paragraph, and include all of those topics in the self-assessment (and perhaps in the new self-monitoring tool, too). It is possible that new tools might include everything that comprises the self-assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. In addition, the action plan and action steps were not accurate in that items marked as completed were not yet completed, or not completed to an acceptable level of quality (e.g., item #1). The provision action information list should not have anything under E, but instead all of the actions should be under one of the five E provision items. This will help avoid duplication, too. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the QA director and believes that the facility was continuing to proceed in the right direction. The facility self-rated itself as being in noncompliance with all five provision items of section E. The monitoring team agreed with these self-ratings.

	Summary of Monitor's Assessment: There was little progress in the development of a quality assurance program at MSSLC. The new QA director, Kim Kirgan, was assigned to other tasks during the past six months. There was, however, a plan for a re-organization of assignments and she will likely have more time to devote to the QA program. The QA department was fully staffed and included two QA nurses and four full time QA program staff. They were engaging, committed, knowledgeable about their tasks, and completely interested in doing their jobs at a quality level. The QA data list inventory was identical to what was submitted six months ago (except for the medical tab). The comments and recommendations in the previous report continued to be relevant and applicable to MSSLC. The QA plan narrative was a reasonable first attempt, but it needed much work to be adequate and useful to the reader. Suggested headings and organization are provided in the report below. The purpose of the QA plan narrative is to give the reader an understanding of the QA program at MSSLC. The QA plan matrix was identical to what was submitted six months ago. The comments and recommendations in the previous report continued to be relevant and applicable. The QA plan matrix should include all key important indicators (i.e., measures, data), that is, a mix of process and outcome indicators for each section of the Settlement Agreement (i.e., each discipline department). The monitoring team recommends there be a monthly meeting of the QA director, SAC, and the lead person responsible for each provision of the Settlement Agreement. The QA department had begun to have a QA report, however, the contents were not presented in a coherent easily consumable manner for the reader. A successful QA report should describe the quality and status of each department/section. Recommendations for format and organization, important indicators/data, and editorial are provided below. MSSLC continued to hold a series of QA-related meetings that had been running for about one year now. Overall, this seemed like a good system for reviewing data at MSSLC. The meetings were the PITs, PETs, QAQI Council, and Executive Management. It appeared that the progress reported on CAPs and the management of CAPs in the previous monitoring report had not been maintained. The monitoring team was given a two-page MSSLC CAPs Tracking document, but could not determine the status of any of these CAPs. Note, however, that the absence of an organized system of CAPs management did not mean that the facility took no actions. For instance, much activity was occurring around medical, aggression, and ISP topics.

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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.	There was little progress in the development of a quality assurance program at MSSLC since the last onsite review. To meet the many requirements of the Settlement Agreement (not only those for section E), MSSLC will need to have a functioning, active, and comprehensive QA program. The QA program plays a critical role in prompting, supporting, and monitoring the facility's many departments to engage in activities to achieve substantial compliance with the Settlement Agreement. The QA program should help guide and manage data systems so that important information is made available to senior management for decision making and intervention. Thus, the MSSLC QA staff should (along with department leads) be coming up with a mix of important indicators (both process and outcome) for each provision of the Settlement Agreement (i.e., the QA plan matrix). Problems should be identified and reviews conducted thoroughly and appropriately (e.g., intense case analysis, route cause analysis). The lack of progress occurred at MSSLC because the new QA director, Kim Kirgan, was assigned to other tasks during the past six months, primarily to managing all DADS ICF regulatory-related activities, such as hosting onsite visits, developing plans of correction, implementing those plans, and reporting on them. Further, she attended numerous meetings, participated in various committees, and made some attempts to address some of the recommendations in the previous report. The monitoring team learned that there was a plan for a re-organization of assignments and, as a result, it was expected that she will have more time to devote to the QA program beginning later in September 2012. <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 four facility-specific policies that were related to quality assurance. Three of them were slightly revised since the last onsite review (Quality Assurance-37, PETs-36, PITs-42). The edits were minor. The QAQI Council policy remained the same. As recommended in the previous monitoring report, training and orientation of both the state and facility policies and their requirements should be provided to QA staff and to senior management, including but not limited to QAQI Council. This appeared to be especially important given the need for the facility to have a strong QA program. Any training should be relevant and practical. Merely walking through the policies, as written, will not be of much interest or use to most managers and clinicians.	Noncompliance

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		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 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 and was disseminated more than six months ago, edits may already be needed. State office should consider this. <u>QA Department</u> Kim Kirgan remained as the QA director. It was good to finally see stability in this important position at MSSLC. Once the facility re-organizes job responsibilities, the monitoring team is confident that Ms. Kirgan will move MSSLC's QA program forward. She was a hard working director, who appeared to care deeply about having a QA program that benefited individuals, managers, staff, and the facility as a whole. She was well respected by facility management and appeared to have their support. Ms. Kirgan actively participated in many meetings and presentations during the week of the onsite review. She never hesitated to ask questions regarding services and supports for individuals, what might be done differently, or how data might be collected so that management would know if things were getting better or worse. This was good to see and makes it more likely that the QA department will be seen as an active part of the services and supports at MSSLC. A productive working relationship between the QA director and the Settlement Agreement Coordinator (SAC) is another important aspect to a successful QA program. The MSSLC SAC, Etta Jenkins, was organized and hard working. She was very knowledgeable about the Settlement Agreement and the workings of the facility. She had numerous responsibilities related to the Settlement Agreement and the QA program. It appeared, however, that the QA director and SAC conducted many of their activities somewhat in isolation from one another. The monitoring team recommends that the QA director and SAC collaborate more. Holding QAD-SAC-Discipline meetings might be one way that this can occur (see below). Further, the monitoring team recommends that the QA director talk with the QA directors at the San Antonio SSLC and San Angelo SSLC regarding the way they collaborate with their SACs. The QA department was fully staffed and included two QA nurses and four full time QA program staff. The QA director held staff meetings once per month. According to the meeting minutes, the meeting content was solely informational announcements for four of the last six	

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		meetings. Two of the meetings included topics for which there had been QA critical incident meetings. Although not the highest priority at this time, the monitoring team recommends that the QA director include some professional development content, so that staff can learn about the profession of quality assurance, participate in creating processes for the department and facility, and so forth. <u>Quality Assurance Data List/Inventory</u> The QA data list inventory was identical to what was submitted six months ago (except for the medical tab which had additional and different data items listed). Given that there were no changes to data list inventory, all of the comments and recommendations in the previous report continue to be relevant and apply to MSSLC. The monitoring team also recommends that the facility consider the possible benefit to there being a system put in place for communication with other SSLCs to share relevant data listing inventory related information. • First, the actual data listing inventory electronic spreadsheets might be shared, so that QA directors can see how their colleagues were meeting this requirement. • Second, whenever there is a serious problem identified related to an important set of data, each facility might be updated and asked to ensure the data are being collected, managed, and reviewed correctly. <u>Quality Assurance Plan Narrative and Matrix</u> The QA Plan should consist of a QA narrative and a QA matrix. MSSLC made some progress by drafting a very initial QA plan narrative. The QA plan narrative focused on the audits done by QA department and/or other staff. Further, it focused primarily (if not solely) on the self-monitoring tools. Although important, the self-monitoring tools should not be the sole set of data reviewed by the QA department, included in the QA matrix and the QA report, and reviewed by QAQI Council. For each provision of the Settlement Agreement (i.e., for each discipline department), there should be a mix of important key process and outcomes indicators (i.e., data, measures). These types of indicators are more likely to point to potential areas for which corrective action must be taken when compared with self-monitoring tool data (which are often presented as percentages). The QA department and the QAQI Council are more likely to take action when they are presented with, and understand, data that represent actual occurrences of processes and outcomes. The MSSLC QA plan narrative was two and half pages long and, although a reasonable first attempt, it needed much work to be adequate and useful to the reader. The monitoring team recommends the QA director write a narrative with the following	

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		suggested headings below. Each should be no more than one or two short, but descriptive paragraphs. The purpose of the QA plan narrative is to give the reader an understanding of the QA program at MSSLC.
		• Comprehensive data listing inventory
		• QA matrix
		  o Key important indicators
		  ▪ Process indicators
		  ▪ Outcome indicators
		  o Self-monitoring tools
		• How data are summarized and analyzed
		• QAD-SAC-Discipline meetings
		• PITs
		• PETs
		• QA report
		• QAQI Council
		• Corrective Actions
		  o CAPs
		  o Route cause analysis, intensive case analysis, fishbone diagram
		
		The QA plan matrix was identical to what was submitted six months ago for the previous monitoring review. All the comments regarding the QA matrix in the previous monitoring report continued to be relevant and applicable to MSSLC and will not be repeated here. To reiterate, the QA plan matrix should include all key important indicators (i.e., measures, data), that is, a mix of process and outcome indicators for each section of the Settlement Agreement (i.e., each discipline department). It is insufficient to only include data from the self-monitoring tools. Also, see section H4 below.
		
		QA Activities
		• QA Staff Activities:
		MSSLC had a very good group of QA staff members and the monitoring team enjoyed working with them during the onsite review. They were engaging, committed, knowledgeable about their tasks, and completely interested in doing their jobs at a quality level.
		
		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 one QA tool, completed statewide self-assessment tools primarily to assess interobserver agreement, and participated on various committees and in meetings.	

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		At the time of the last review, the QA department implemented two tools. At this time, the Quality Assurance Monitoring Form was still being used, but the Active Treatment Monitoring and Coaching Guide was discontinued. The QA department was, understandably, unable to keep up with completing both tools. They correctly chose to continue with the one that was more manageable and that sampled from important areas of service and support. The QA Monitoring Form, revised on 5/23/12, contained four sections (engagement, home environment, individual's programming, health-related info.). One individual was chosen for each form completion. The monitoring team reviewed 40 forms completed by six different QA staff between 6/16/12 and 8/29/12. The QA staff wrote comments along with their yes/no ratings. This was very helpful to the reader and should be continued, especially given that this was the only tool implemented specifically and solely by the QA department. The comments by Ms. Kimbriel were particularly detailed and informative. Two of the QA staff recorded yes for every item on all of their forms. The QA director should examine this because it begged the question of inter rater reliability. Additionally, the QA director graphed the results of these completed forms. That was good to see. The monitoring team recommends that she make five small graphs on one page for each unit rather than having all the data lines on top of one another. Further, a more thorough review of the completed forms should be done by the QA director to tease out any consistent problems that might otherwise not be evident when data are presented as percentages (e.g., a percentage score of 90% might make it appear that all was well when there might indeed have been a consistent problem with a specific item, such as explaining the steps for reporting abuse or neglect). The QA department also had a number of data sets. They are listed below. Overall, these appeared to be reasonable and potentially useful sets of data, however, there was no organization of these reports and documents. That is, it was not clear how these data were reviewed and summarized or how they fit into the overall QA program, QA data listing inventory, QA plan narrative, QA plan matrix, QA report, etc. • Statewide trend analysis o This was a standard four component quarterly report with data for the past few years. The monitoring team requested the entire report for the past two quarters, but instead received various pieces of this report, such as restraints and abuse/neglect for one quarter ending 5/31/12, unusual incidents for one quarter ending 8/31/12, injuries for one month August 2012, restraint usage for one month July 2012, and unusual incidents for three years ending 6/30/12. Thus, it appeared to the monitoring team that these data sets were not being used by the QA program or the appropriate facility departments. • DADS regulatory visit log, December 2011 through September 2012	

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		• DADS regulatory tag tracking log • Follow-up to QA critical incident meetings, two, 3/15/12 and 5/10/12 • Incident Management Review Team end of month report of tracking of IMRT recommendations, May 2012 to August 2012 • Completed IMRT recommendations, tracking instrument, 29 pages, 8/3/05 (sic) • Open IMRT recommendations, tracking instrument • Enteral feeding tube replacement data, 8/21/12 • Internal medical management audits, round 5, 7/16/12 • FSPI, two indicators, FY12 • Retail food establishment inspection report, 6/28/12 The QA director was not yet regularly assisting the discipline departments in creating data collection tools, graphs, and databases. The QAD-SAC-Department meetings described below may help set the occasion for this to occur more regularly. There was a 30-minute training in July 2012 by the QA director for most of the facility's department and section leaders (18 people). The topic was inter rater reliability and the monitoring process. This type of training was good to see. • Self-Monitoring Activities: Since the last review, the DADS state office had given new direction to the facilities regarding these tools. The monitoring team's understanding was now that each facility could choose to use the current statewide tools, modify the current tools, or develop new tools. Thus, Settlement Agreement self-monitoring tools could become facility-specific. State office approval was not required, however, the facility department head was supposed to collaborate with his or her state office discipline coordinator. Further, state office did not require the facility to have any specific type of facility-level review and approval process, other than the involvement of QAQI Council. On the other hand, it seemed that the state office discipline coordinator could require the facilities to all use the same tool. According to the QA director, every discipline was continuing to use the state-issued self-monitoring tools, except for nursing, which had either modified some of the tools and/or created new tools. Self-monitoring tools can be very helpful if done correctly and if they direct managers to important areas and activities. That is, the content needs to be valid and needs to line up with what the monitoring team is assessing. Thus, the self-monitoring tools should become an important part of the self-assessment process for each provision. It may be that a well-designed and comprehensive self-monitoring tool <u>is</u> the self-assessment, or it	

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		may turn out that self-monitoring tool is but one of a number of sources of data and information that the department uses in self-assessing its substantial compliance with each provision item. The monitoring team has commented on the facility's self-assessment of each provision at the beginning of each section of this report. There are some important considerations as the facility revises/creates self-monitoring tools (some of the following is repeated from the previous monitoring report): • Again, the content of the tools should be relevant and valid. • Some items in each tool may be more important than others. These should be highlighted in some way (e.g., weighted, asterisked, labeled as essential). • Consideration should be given to the frequency of completion of each tool. Some might only need to be completed periodically. • Attend to duplication of efforts, such as two observers sitting in the same ISP meeting when it might have been done by one observer. Additionally, to reiterate, it is insufficient for the only measures to be the self-monitoring tools. Instead, what is needed is a mix of process and outcome important key indicators (with data collected, summarized, and reviewed) for each provision of the Settlement Agreement. • Satisfaction Measures: As discussed in previous reviews, a variety of satisfaction measures are important indicators to include in a comprehensive QA program. No progress was made on this. First, although the family/LAR satisfaction survey continued and it was good to see that there were an additional 24 respondents since the last review, nothing was done with the data and information. Thus, the same comments made in the previous monitoring report remained relevant and applicable. Similarly, comments from the previous report regarding individual, staff, and community businesses were also still relevant and applicable (and are not repeated here). The self-advocacy committee can provide one way to get at individual satisfaction. There was a new human rights officer. She was struggling to have a monthly self-advocacy meeting and for there to be attendance and participation from individuals. The monitoring team recommends that she find out how some of the other SSLCs are handling self-advocacy activities (e.g., San Angelo SSLC, San Antonio SSLC, El Paso SSLC). That being said, MSSLC continued to have a suggestion box system. This system allowed any staff (or individuals) to make a suggestion or comment. Most impressive was that the MSSLC management responded to every one of the items, as appropriate and as possible. As a result, there was regular participation from staff. The facility continued to	

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		graph the number of suggestions per 10 topic areas. Even more helpful would be to provide graphs showing if the number of suggestions was increasing or decreasing. Then these data might be included in the QA program as one measure, perhaps, related to staff satisfaction. <u>Other QA Activities at MSSLC</u> A number of QA-type activities were occurring at MSSLC or were going to occur over the few months. The QA director should incorporate these into her overall QA program, that is, include the data in the listing inventory, QA plan narrative, and QA matrix, as appropriate, and review data and reports, as appropriate. • Medical: The medical director was planning to develop a medical quality program as required by section L. • Nursing: The nursing department and the QA nurses collected a lot of data regarding the performance and activities of their department. See section M. • QDDPs: a quality program regarding ISPs was needed as required by section F2g. • Admissions and placement: a quality assurance system was needed as required by section T1f. • Statewide trend analysis: discussed above in this section E1.	
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, QA-related meetings, the QAQI Council, the use of facility/performance improvement activities, and the management of corrective actions and corrective action plans. Some 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 for all of the items in the QA matrix (as noted in E1, however, the QA matrix was not yet adequately completed). The importance of QA department review of data plays a very important role in the QA process. The facility should set an expectation for the provision leaders/service departments to submit data and graphic summaries each month of their self-monitoring and their key process and outcome indicator data. Some of this might be accomplished during QAD-SAC-Department meetings, which are discussed below. Many of these graphs can be inserted into the QA report and be presented to QAQI Council. But again, the QA department should be managing all of the data on the QA	Noncompliance

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		matrix of which some, but not necessarily all, will end up in the QA report. <u>Monthly QAD-SAC meeting with discipline departments</u> • The monitoring team recommends there be a monthly meeting of the QA director, SAC, and the lead person responsible for each provision of the Settlement Agreement. During these one-hour meetings, review QA-related actions, review the data listing inventory, discuss/determine key indicators and outcomes, review conduct of the self-monitoring tools, create corrective action plans, and review previous corrective action plans. A set of graphs can portray the discipline's performance on the metrics that are part of the meeting agenda. The monitoring team believes these meetings, although time consuming for the QA director and SAC, can be an excellent part of the QA program. o The monitoring team and the QA director discussed this at length during the onsite review. The QA director said she would consider this. She was unsure if they would replace the PET groups. <u>QA Report</u> QA reports were created each month beginning in June 2012. There were a total of three. Each QA report contained data and information for a set of Settlement Agreement provisions. Across the three months, 13 of the 20 provisions were presented. Although it was good to see that the QA department had begun to have a QA report, the three reports were really nothing more than a print-out of a variety of tools and charts that were not presented in a coherent easily consumable manner for the reader. For example, in the July 2012 report, there were dozens of pages showing the actual scoring sheets for every question by the self-monitors. It is unreasonable to expect managers to have to spend time trying to understand what is, and is not, important in these pages. Some section leaders, however, tried to do some summarizing (e.g., section K, section T) in addition to pages of data/forms, but they were not successful in making a QA report, that is, a report on the quality/status of their department/section. As noted in many places in this report, the QA director might talk with her colleagues at other SSLCs and see how they have designed their QA reports. In addition, the monitoring team provides some guidance to the QA director below. Format and organization: • The report should be divided into sections and should have a table of contents. One possible way to organize the report is as follows: o Settlement Agreement provisions that are in that month's report(this will be the largest section of the QA report) and will include: ▪ the statewide (or facility-made) self-monitoring tools	

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		▪ other key important indicators (see below) o DADS regulatory ICF information o FSPI information o Important PIT information from each unit director o Work group updates o Other important indicators (if any) o CAPs update/summary • A short explanatory paragraph should be included in each Settlement Agreement section. The narrative paragraph should <u>not</u> be primarily about the mechanics of the data collection or a description of the scores. Instead, it should be an analysis paragraph. It might read, for example, "The three most important things to know about this month's data are…" • Some CAP information should be in the report. The monitoring team recommends a simple piece of data, such as the number of CAPs that are active at this time. Individual CAPs should not be included in the QA report. Important indicators/data: • The provision leaders should present key, important, relevant data (process and outcome) in addition to the statewide (or facility-made) self-monitoring tool data. The purpose of the QA report is to present the status of progress in each provision, therefore, data in addition to self-monitoring tools is required. • QAQI Council could help the department head determine what else to present. One way would be for the QAQI Council to refer to the data listing inventory to see what other types of data were being collected in the department. • Determining what other key indicator data to present could also be a topic during the monthly QAD-SAC-department meetings, if those are implemented. • Consider key indicators/data related to what is reviewed by the monitoring team. • Consider the major issue(s) raised in the previous monitoring review. Editorial: • Start each provision on a new page. • If there were no observations (i.e., no data available), the graph should have no data point for that month. The absence of data should not be graphed as a zero. • Do not put individual practitioner or clinician names in the report, especially not associated with specific data findings.	

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		QA-Related Meetings MSSLC continued to hold a series of QA-related meetings that had been running for about one year now. Overall, this seemed like a good system for reviewing data at MSSLC. • Performance Improvement Teams: PIT meetings occurred once per month per unit and were led by the unit director and were described in the previous report. The monitoring team attended two of these meetings. Good information was presented and there was good discussion among participants. o The monitoring team met with the unit directors and clarified that the PIT meetings were for their benefit. Therefore, they should modify the content as appropriate for the individuals who lived on their units. Similarly, graphic summaries of data should be done in a way that is helpful to the unit directors in understanding the trending of the data that were being reviewed. Thus, the type, number, and content of graphs may vary from unit to unit and from data set to data set. • Performance Evaluation Teams: The 20 provisions of the Settlement Agreement were divided into four groupings, each was called a PET. PETs were described in the previous report. The monitoring team attended the PET IV meeting. There was improvement in discussion and participation compared to the PET meeting observed last time. As is often the case, it appeared that this was directly due to the presentation of data, tables, and graphs. There was good discussion about integrated clinical services, UTIs, CAPs, waist measurements, and MOSES/DISCUS data. The SAC did a nice job in leading and facilitating the meeting. • QAQI Council: This meeting plays an important role in the QA program and is to be led by the facility director. There was an improvement in participation in discussion compared to the last onsite review. The monitoring team, however, noticed that the unit directors presented PIT data that were two months old. For instance, this QAQI Council meeting occurred at the very end of September. The unit directors presented information from the PIT meeting they held in August. At that meeting in August, they reviewed data from July. The monitoring team recommends that the delay in data be addressed. • QA director participation at Executive Management: The facility director held a weekly meeting of his senior management team. The QA director was part of this team and attended these meetings. This presented an excellent opportunity for the QA director to bring to this executive team whatever she thinks is important for them to know about.	

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		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. For instance, at a minimum, there should be a listing of these workgroups, their goals, progress, and accomplishments. It seemed to the monitoring team that there were work groups regarding peer to peer aggression (a recommendation in the previous report), enteral feeding, the use of Vicodan, and the frequency of g-tubes being pulled out. In some cases, work groups were formed when QA was asked to "look into" an issue. On the other hand, there were corrective action plans for some of these topics, so it was confusing as to what was a work group, what was a CAP, and/or when a work group was formed as part of a CAP. Corrective Actions It appeared that the progress reported on CAPs and the management of CAPs in the previous monitoring report had not been maintained. Last time, there were seven CAPs. The QA director reported that the same seven CAPs remained. The monitoring team was given a two-page MSSLC CAPs Tracking document, but could not determine the status of any of these CAPs. Moreover, the monitoring team counted nine CAPs on this document, but could not determine the status, progress, or monitoring of any of them. The QA director also reported that there were three new CAPs since the time of the last review. One of these (pain medication) also appeared on the list of seven old CAPs. Further, the two-page handwritten forms that helped the CAPs developer cover lots of important topics, as well as obtaining signatures of department and QA staff, did not appear to be continued because nothing of this sort was given to the monitoring team (perhaps they were still in progress). As the QA director begins to devote her time to the QA program, she will need to also better organize and manage the system of corrective actions and CAPs, including keeping track of facility improvement work groups versus CAPs, and addressing the CAP-related requirements of E2, E3, E4, and E5. The monthly QAD-SAC-Department meetings can also present an opportunity for the review and documentation of the status of every CAP. Lastly, the QA director should maintain some simple data regarding CAPs, such as the number of CAPs that are active at this time. Note, however, that the absence of an organized system of CAPs management did not mean that the facility took no actions. For instance, much activity was occurring around	

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		G- and J-tube care, and integration of the ISP and at-risk processes. In another example, the RN meeting agenda of 8/7/12 detailed discussion of a CAP related to allergies and changes the nursing and pharmacy staff were going to implement. This was all good to see.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	MSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	MSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	MSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

Recommendations:

1. Provide training and orientation of both the state and facility policies and their requirements to QA staff and to senior management, including but not limited to QAQI Council. (E1).
2. Implement the statewide discipline QAQI committees, as per the new state policy (E1).
3. Explore ways for the QA director and SAC to work together on QA and Settlement Agreement activities (E1).
4. Include some professional development in the monthly QA department's staff meeting (E1).
5. Make a comprehensive listing/inventory of all data collected at MSSLC (E1).
6. Edit the QA plan narrative as suggested in E1 (E1).
7. Follow the suggestions regarding the QA matrix presented in E1 (E1).
8. Develop key indicators/data (process and outcome) for each of the Settlement Agreement provisions. See guidance provided in E1 and E2 (E1, E2).

9. Review the comments regarding the QA Monitoring Tool provided in E1 (E1).

10. Organize the many sets of data, such as those listed in E1 because it was not clear how these data were reviewed and summarized or how they fit into the overall QA program (E1).

11. Determine how to best use the statewide self-monitoring tools. Consider the suggestions made in E1 regarding development of facility-specific self-monitoring tools (E1).

12. Use data from the family survey and begin to address satisfaction measures for staff, individuals, and community businesses (E1).

13. Include in the MSSLC QA program, any data/information from any other QA-related activities occurring at the facility (E1).

14. Ensure that the QA department reviews all data on data matrix (E2).

15. Consider holding monthly QAD-SAC-Department meetings. Structure them and document the meeting (E2).

16. Consider the suggestions provided in E2 regarding the QA report regarding format, indicators/data, and editorial (E2).

17. Keep a list of the many committees and work groups at MSSLC (E2).

18. Create a system to meet the CAPs requirements (E2-E5).

19. Keep simple data on CAPs (E2).

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 MSSLC Section F Presentation Book o MSSLC Self-Assessment o Q Construction Facilitation Monitoring Form o ISP Checklist for QA o A sample of completed Section F audits done by MSSLC o ISP Draft for Individual #151 o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews: • Individual #157, Individual #287, Individual #325, Individual #451, Individual #446, and Individual #451. <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 Alynn Mitchell, Acting QDDP Coordinator o Joy Lovelace, Human Rights Officer <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 9/24/12 and 9/26/12 o ISP preparation meeting for Individual #94 and Individual #441 o Annual IDT Meeting for Individual #151 o Shamrock PIT Meeting 9/26/12 o Longhorn PIT Meeting 9/27/12 o Restraint Reduction Committee Meeting 9/27/12 o Quarterly QA/QI Meeting

	Facility Self-Assessment: MSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 8/23/12 with recent activities and assessment outcomes. The QDDP Coordinator was responsible for the section F self-assessment. The facility had added a number of activities to the self-assessment efforts in regards to section F. The self-assessment commented on findings from a monthly sample of Settlement Agreement Monitoring Tools (SAMTs) completed by the QDDP Director, QDDP Coordinators, and QDDP Educator, as well as, other activities for each provision. For example, to assess QDDP facilitation skills, the self- assessment described findings from SAMTs, Q Facilitation Monitoring Forms, data collected on assessment submission and meeting attendance, and data regarding QDDP monthly reviews. This type of in-depth assessment should be beneficial in determining where to focus efforts to gain compliance with section F. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts to develop an accurate audit system and believes that the facility was continuing to proceed in the right direction. The QDDPs were recently trained on the new ISP process that was designed to meet the requirements of the Settlement Agreement. Moving forward, the facility can begin to assess the impact of that training. The facility self-rated itself as being out of compliance with all provision items in section F. The monitoring team agreed.
	Summary of Monitor's Assessment In May 2012, DADS State Office had revised Policy #004.1: Individual Support Plan Process, and had provided the monitoring teams with a draft copy. DADS state office recognized that the previous ISPs did not meet the requirements of the Settlement Agreement. As a result, using a group of consultants as well as work groups that included state office and facility staff, the ISP planning and development processes had been revised and reflected in the draft policy. In July 2012, MSSLC QDDPs and many team members had been provided training on the new process by statewide consultants. In addition, forensic consultants were working with MSSLC to specifically address systemic issues related to providing supports to a forensic population. In consultation with the parties, it was agreed that beginning in August 2012, the monitoring teams would only review and comment on the ISP documents that utilized the newest process and format. MSSLC had recently received training on the new process from state office consultants. The first IDT meeting held in the new format was during the week of the monitoring visit. Thus, the new ISP process had not yet been completed for any individuals at MSSLC. The intention of limiting the monitoring teams' review to newer plans is to provide the state and facilities with more specific information about the revised process. Compliance will then be contingent on both the new plans meeting the requirements, and a sufficient

	number of individuals having plans that meet the Settlement Agreement requirements. Since there were no ISPs yet available that were representative of the new ISP process, this review was limited to data gathered through the facility's self-assessment process and limited observation of the new process. The QDDP Director had recently retired and the Director of Admissions and Placement was appointed the Interim QDDP Director in July 2012. This seemed to have slowed progress in meeting compliance with section F requirements. There had, however, been some positive steps forward with the new ISP process. • The QDDP department was tracking completion on annual assessments and attendance at the ISP meetings. • ISP Coordinators had been reassigned to conduct the annual ISP meetings and ensure that information discussed at the meeting was included in the ISP. • QDDPs and Admission /Placement staff had received training on the Most Integrated Setting Policy and the CLDP process. • Training had begun on the new ISP process. The monitoring team observed one annual ISP meeting in the new format. The IDT was not yet competent at developing an integrated plan that included all needed supports and services based on preferences and needs of each individual. It was apparent that the IDT was attempting to follow the format of the new ISP process and include all required information in the plan. The team, however, did engage in a much more integrated discussion of his preferences and needs.

#	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.	During the week of the review, the monitoring team observed one ISP meeting in the new format. The completed written plan was not yet available for review. The ISP Coordinator facilitated the meeting. Progress definitely continued to occur and was evident, with regard to the facilitation of meetings. The ISP Coordinator came to the meeting prepared with a draft Integrated Risk Rating Form and a draft ISP format. These documents provided team members with some relevant information and assisted the team to remain focused. She kept the meeting moving and encouraged discussion among team members. The facility was working to fill seven vacant QDDP positions. The facility recognized that there were lapses in ISPs due to larger caseloads distributed among QDDPs. The facility self-assessment indicated that from a sample of 18 ISPs, three (17%) were not completed	Noncompliance

#	Provision	Assessment of Status	Compliance
		on time. The facility had a tracking log that included due dates and completion dates for all ISPs. This will be useful for ensuring that ISPs are completed on time. The facility then needs to ensure that plans are distributed and available to staff implementing the plan. While progress had been made towards meeting substantial compliance, it will be important for the QDDPs to continue to develop facilitation skills that will allow them to ensure that meetings result in comprehensive support plans that focus on the individual's strengths and preferences. The plan should then be monitored and revised as needed. The facility remained out of compliance with this provision item.	
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.	DADS Policy #004 described the Individual Support Team as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP, direct support professionals, and persons identified in the Personal Focus Meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Personal Focus Assessment (PFA) was the document that should have identified the team composition based on the individual's preferences, strengths, and needs. The facility had begun to track data on attendance at IDT meetings. The facility self – assessment indicated an 82% compliance rating in meeting attendance from a review of 18 ISPs developed between 2/1/12 and 8/13/12. Data compiled using the new attendance database for June 2012 and July 2012 for all ISPs developed during those two months showed a much lower percentage rate for attendance by some departments. For example, • A nutritionist was only present for five (7%) of 69 IDT meetings. • Speech/communication was present at 19 (28%) of 69 meetings. • Psychiatry was present at 18 (26%) of 69 meetings. Although it is understandable that all disciplines will not be able to have a representative available for all IDT meetings, when input is critical from a particular discipline, the team needs to ensure that discipline is available for discussion with the IDT. At the IDT meeting for Individual #151, for example, there was a significant amount of discussion regarding his physician's recommendation for 24 hour access to a respiratory therapist in regards to his placement and support. The physician attended the meeting, but was unable to stay for the entire discussion. The team had many questions regarding the recommendation and should have sought clarification from the physician prior to making placement decisions. The IDT agreed to move him to another SSLC that had a respiratory therapist available a greater number of hours (though less than 24 hours per day),	Noncompliance

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		without consideration of his or his family's preferences or clarification of the recommendation from the physician. The state had recently developed a new tool to assess personal preference and support needs. The Preferences and Strength Inventory (PSI) was similar to the PFA and should serve the same purpose in identifying key team members. The facility had just begun using the PSI process to plan for the annual IDT meeting. A sample was not available for this review. ISP preparation meeting were observed for Individual #94 and Individual #441. • For Individual #441, the team completed the PSI form regarding his preferences and any assessments that he would need prior to his annual meeting. Progress towards outcomes was briefly reviewed. Core team members were in attendance at the meeting and gave input. There was little integrated discussion. • The ISP preparation meeting for Individual #94 was focused on his risk level. The team reviewed his risk levels in each area and assigned a preliminary rating of high, medium, or low to each risk category. The nurse led the risk discussion, but there was very little discussion or input from other team members. The QDDP asked good questions regarding the assignment of risk ratings, but did so apologetically. There was little discussion among team members. There was a brief discussion of his optimal placement at the end of the meeting. He had been referred for community placement and the team agreed that the referral was still appropriate. QDDPs will need additional training on conducting ISP preparation meetings. A standard format should be used to ensure that outcome of the meeting is consistent. A small sample of the most recent ISPs provided to the monitoring team was reviewed for attendance at team meetings by key team members. This included ISPs for Individual #157, Individual #287, Individual #325, Individual #451, and Individual #446. A fully constituted team was only present for one individual in the sample (Individual #446). An example where an adequate team was not present was the IDT for Individual #157. His IDT should have included his father, a speech therapist, his psychiatrist, his dietician, and direct support staff. None of these team members were in attendance at this annual IDT meeting. The self-assessment indicated that the facility was not yet in compliance with requirements for the IDT to accurately identify key team members. The monitoring team agreed that a system was not yet in place to ensure input from all needed team members.	

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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.	DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration. The facility had begun to gather data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of assessments for 57 individuals indicated: • 481 assessments were submitted on time, • 189 assessments were submitted late, but still prior to the ISP meeting, • 292 assessments were submitted after the ISP meeting, and • 106 assessments were either never completed or not 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). The facility was using Personal Focus Assessment (PFA) as a screening tool to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. The PFAs now identified relevant assessments that should be completed prior to the ISP meeting. This is a positive step forward towards compliance with F1c. The state had recently developed a new tool to assess personal preference and support needs (and to replace the PFA). The Preferences and Strength Inventory (PSI) was similar to the PFA, but was designed to be a rolling document that could be updated throughout the year as new preferences were identified or as preferences changed. As noted in section J, the psychiatry clinic forum was functioning like a mini ISP given the number of staff in attendance and participation in the review of the individual's treatment plan. Further, psychiatry was now completing an electronic QPMR form. The facility self-rated F1c as not in compliance based on the timely submission of assessments. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		when applicable. The facility was not yet in compliance with this item based on data available.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As described in F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for IDT members to review each other's assessments prior to the ISP meeting. 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. Recommendations resulting from these assessments need to be addressed in the ISPs either by incorporation, or by evidence that the IDT considered the recommendation and justified not incorporating it. Most of the ISPs failed to adequately incorporate the individuals' health problems, needs, and risks into their plan for daily living and participation in work, leisure, community activities, etc. For example, although Individual #54's 10/26/11 annual ISP noted his medical history and current diagnoses, there was no evidence that his behavior and health problems/risks were integrated, thus, there were no references to risks of his inappropriate sexual behavior and exposure to sexually transmitted diseases. An ISP completed in the new format was not yet available for review to determine if recommendations from assessments were integrated into the plan. The facility self-assessment indicated that the facility was not yet in substantial compliance with this requirement.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	DADS Policy #004: Personal Support 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. The ADA and Olmstead Act require that individuals receive services in the most integrated setting to meet their specific needs. Training provided to the facility by DADS consultants included facilitating the living options discussion to include input from all team members. QDDPs and Admission/Placement staff had received additional training on the Most Integrated Setting Policy and the CLDP process. The facility self-assessment indicated that 113 ISPs were reviewed using the Individual Support Plan Checklist prior to distribution. In 78%, barriers to community placement were adequately addressed according to the checklist. Out of 18 ISPs reviewed using the Settlement Agreement Monitoring Tool, however, only 56% met compliance requirements. The self-assessment noted that, based on the forensic population, the	Noncompliance

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		IDTs need to develop more realistic goals and plans to assist individuals to transition safely into the community. The facility had developed a workgroup to assist the IDTs in developing meaningful learning opportunities, job and relationship opportunities in the community, and to develop additional opportunities for training at the facility that would be functional in the community. This workgroup included the Director of Education and Training, the Community Relations Director, the QDDP Educator, and the Assistant Independent Ombudsman. The group had begun providing training to IDTs. Positive progress was evident in more recent ISPs reviewed. The IDT members, at the ISP meeting observed by the monitoring team, for Individual #151 engaged in a lengthy discussion regarding the least restrictive setting based on his support needs. It was evident that the team members had discussed placement options prior to the annual meeting and all team members were in agreement that he should remain in an SSLC. The team had referred him for placement at another SSLC due to his healthcare needs. As noted in F1c there were some unanswered questions regarding his specific support needs. The LA summarized community living options and the family's preferences. He had the opportunity to go on community placement visits and the team acknowledged that he appeared to enjoy the visit. His family reportedly indicated that they would like him to live closer to them. The IDT, however, agreed that community placement was not an option due to his healthcare needs. Team members were asked individually for recommendations for placement. All agreed to refer him to another SSLC. Prior to making the referral, the team should have clarified his support needs and ensured that those supports would be available. Another positive development that had occurred since the last monitoring visit was that all students enrolled in MISD were now attending school in the community. During the previous school year, many students were attending classes at MSSLC. This option was no longer offered. The facility was attempting to offer more structured training in the community and training opportunities were better documented. In the sample of newer ISPs reviewed, outcomes were included for a wider range of individualized training in the community. Community employment opportunities were still limited, but vocational staff were doing more thorough assessments and referring some individuals to DARS for further assessment. The facility self-assessment determined that this item was not yet in substantial	

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		compliance. The monitoring team agreed with this self-rating. Also see section T of this report.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	DADS Policy #004 at II.D.4 indicated that the Action Plans should be based on prioritized preferences, strengths, and needs. The policy further indicated that the IDT "will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." In order to meet substantial 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. The IDT for Individual #151 did not discuss how identified supports would be integrated throughout his day. For example, communication recommendations were made, but those recommendations were not integrated in his support plan to be included throughout his day. Furthermore, observation across the MSSLC campus by the monitoring team did not support that individuals were spending a majority of their day engaged in activities based on their preferences. According to data presented in two unit PIT meetings attended by the monitoring team, there were frequent refusals to attend programming. Engagement levels varied in homes observed. There was minimal improvement in some of the homes in offering active treatment opportunities based on preferences, while in other homes good interaction and engagement was observed. It was noted during observations throughout the homes that 1:1 staff were often interacting with other staff members or completing paperwork or other duties while the individual assigned 1:1 staff remained unengaged. As noted in F1e, however, the facility had made progress in developing measurable	Noncompliance

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		training in the community. The facility was not in compliance with this item.	
	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. The facility self-assessment indicated that IDTs were still struggling with developing realistic individualized goals. It was also noted that assessments were not yet individualized. Adequate data were not available for the monitoring team, to determine compliance (i.e., no new style ISPs were yet available for review). The facility will need to assess whether or not IDTs are adequately identifying each individual's preferences, support needs, and barriers to living in a more integrated setting prior to assessing compliance with the requirements of F2a2.	Noncompliance
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The outcome of the new ISP process should be a plan that integrates all protections, services and supports, treatment plans, and clinical care plans. The new ISP template included prompts to guide the IDT discussion and ensure that important information would not be omitted during the planning process. At the ISP meeting observed for Individual #151, the team engaged in an integrated discussion regarding his support needs and preferences. The team brainstormed ways to include his preferences throughout his day. This was a much better discussion than was observed during the last monitoring visit. The facility self-assessment process found that assessments were not always submitted 10 days prior to the annual IDT meeting and available for review by team members, so that information could be integrated among disciplines. Habilitation therapists had developed a handful of treatment interventions and programs, but very few of these appeared to actually be a part of the ISP or added via an ISPA. The documentation for these was on a separate form with limited information provided and filed in the Habilitation Therapy tab of the individual record, so were not readily available to other team members. 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

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	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. There was not a sample of new ISPs to review for compliance with this requirement.	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	There was an increase in functional learning opportunities observed during the week of the monitoring visit. The facility was doing a better job of developing specific functional objectives to be implemented at both the facility and in the community. A growing number of formal training opportunities were offered in the community. Interventions, strategies and supports will need to adequately address individual's needs and be both practical and functional at the facility and/or in community settings.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	DADS Policy #004 specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection required for monitoring of the plan. ISPs in the new format will be reviewed for compliance during the next monitoring review. Also 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 goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision item will require that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services. Please refer to these sections of the report regarding the coordination of services as well as G1 regarding the coordination and integration of clinical services. As noted in F1b and F1c, adequate assessments were often not completed prior to the annual meetings. IDTs will need to work together to develop ISPs that coordinate all services and supports. Recommendations from various assessments should be integrated throughout the ISP. The facility did not have a process to ensure coordination of all components of the ISP.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two	A sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in 10 out of 12 (83%) records reviewed. Risk action plans were not found to be a part of the ISP in the individual notebooks. IDTs were spending a	Noncompliance

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	years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	considerable amount of time developing risk action plans as part of the ISP process. The outcome of this deliberation should be to develop a plan that staff can access and use as a guide for minimizing risks for an individual. A system needs to be put into place to ensure records contain current ISPs that include all action plans. The facility had begun to monitor active records for inclusion on the ISP using the Checklist of QDDP Documentation Required in Active Record. Audits of all records had not yet been completed. 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.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	QDDPs were completing a monthly review of services, supports, and outcomes for each individual. IDTs were no longer routinely holding quarterly review team meetings. Team's routinely met to review any incidents, significant injuries, or changes in status immediately when determined necessary. It was not evident teams were using the monthly review process to ensure that all services and supports were in place or supports were modified when changes in status occurred. For example: • The monthly reviews for May 2012 through August 2012 for Individual #287 noted that data were not available for review for many outcomes each month. There was no evidence that the QDDP followed up on this. The June 2012 monthly review noted "no problem" in the comment area regarding his nine education and training outcomes, though there were no data available for two months. He had abnormal lab results for three reporting periods. There was no evidence of follow-up. • The monthly reviews for Individual #325 from March 2012 through July 2012 indicated that a community risk assessment had been requested by the team for each month reviewed. There was no evidence that the assessment was ever completed. Data collected for each of his SPOs showed 0% progress on all outcomes for each month reviewed. No revisions were made to his outcomes. The QDDP wrote "continue" for each outcome. 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	Noncompliance

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		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 updated competency- based training when the plans are revised	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. The facility was still waiting for additional training to be provided by the state office on developing and implementing the ISP. QDDPs were still learning to use the new statewide ISP format. The facility was aware of deficits in the implementation of the ISP and was providing additional training to direct support staff. This had improved implementation in some homes. Some staff interviewed throughout the week of the monitoring team could not accurately identify supports for individuals whom they were assigned to work with. The facility self-rated the provision as being out of compliance with this requirement. The monitoring team agreed with that assessment.	Noncompliance
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	As noted in F2c, a sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current plans were available in 10 of 12 individual notebooks in the sample. Informal interviews with staff indicated that not all staff were adequately trained on the requirements of individual ISPs. Familiarity with plans varied widely from home to home. Some staff interviewed were able to summarize outcomes, PBSP, therapy plans, and health risks for individuals whom they were assigned to support, while other staff interviewed were not able to describe interventions for even the most significant health risks for individuals whom they were assigned 1:1 supervision. The facility was rated as being out of compliance with this provision item.	Noncompliance

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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 was using the statewide section F audit tool to monitor requirements of section F. Other tools had been developed to measure timeliness of assessments, participation in meetings, facilitation skills and engagement. Quality enhancement activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility staff had made some good 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. Efforts need to be made to ensure all team members are in attendance at IDT members in order to ensure adequate integration occurs during planning (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, and increased exposure to life outside of the facility (F1e).

8. 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).

9. 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).

10. 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)

11. 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).

12. 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).

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

14. 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).

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

16. 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).

17. 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 scheduled monthly reviews. 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).

18. 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 Self-Assessment o MSSLC Action Plan for Sections G and H o MSSLC 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, 2012 Interviews and Meetings Held: o Dolores Erfe, MD, Medical Director o Angela Johnson, RN, Medical Compliance Nurse Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Psychiatry Clinics o Dental Clinic 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, activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. For provision G1, the medical director listed four activities. Two were related to meeting attendance. One assessed the involvement of clinical disciplines in pretreatment sedation and the last related to nursing services contacting other discipline with care issues. It may be important to consider other activities, as well, such as the quality and outcomes of the meetings. The assessment of provision G2 included audits of the IPNs of active records and reviews of consults to determine if documentation occurred as required. In moving forward, the monitoring team recommends that the medical director review this report. For each provision item in this report, the medical director should note 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. Again, the state draft policy should also be reviewed for additional

	guidance. The facility found itself in noncompliance with provisions G1 and G2. The monitoring team found the facility in noncompliance with both provision items.
	Summary of Monitor's Assessment: The facility made forward, incremental progress in this area. There was no policy to guide this procedure and no adequate means of assessing progress. MSSLC had not implemented any facility initiative that was intended to specifically foster integration among the clinical disciplines. A document was drafted that listed the responsibilities of each discipline and the committees in which they participated. The document did not focus on how the disciplines integrated with one another. The monitoring team had the opportunity to meet with the medical director and medical compliance nurse to discuss integration activities at the facility. During this meeting, it was evident that some degree of integration was occurring. It was equally as evident that there was no overarching plan for how MSSLC would achieve integration of clinical services. Integration had not been defined and, therefore, could not be adequately measured. Throughout the week of the review, the monitoring team encountered a few 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.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The medical director served as the lead for this provision. The monitoring team had the opportunity to meet with the medical director and medical compliance nurse to discuss integration activities at the facility. They did not have a great deal of documentation or written information to share. The presentation book was less than 10 pages. The discussion related to the tracking of integration of clinical services that occurred in the PET meeting attended by the monitoring team on 9/26/12 did not surface during this meeting. Additionally, the draft policy that was presented during the March 2012 meeting was never approved or adopted. It was reported that no feedback was received from state office. The medical director presented a document related to integration for the various clinical services. For each clinical department, there were one to two paragraphs that essentially described the job duties for the discipline. For example, the PCP provided access to a personal physician, served as the physician referral source, and provided a history and physical upon admission. Nursing implemented measures to ensure a safe environment,	Noncompliance

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		performed routine and emergency procedures, delegated, and supervised nursing care that was approved by others. The second half of the document outlined committees. According to the document, "The final phase of the integration of clinical services process occurs when the clinical staff attends the Mexia State Supported Living Center's various meetings which gives them the opportunity to collaborate and to present valuable information to address every area based on assessment results." To this end, all of the various committees attended by the clinical disciplines were listed. The monitoring team would like to emphasize that integration of clinical services refers to the services received by the individuals. The various committees and activities are surrogate metrics and are not the actual end measures. The daily clinical services meetings were excellent opportunities to facilitate the integration of services, however, occurrence of the meeting in and of itself did not imply that integration of services had occurred. The medical director also discussed and provided some examples of integration of clinical services including: • Medical Review Committee • Neurology-psychiatry Clinic • Pretreatment sedation meetings • PCP participation in team meetings • Post hospital PNMT meetings 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, several 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 facility continued to conduct this meeting each weekday morning. Participants included the medical director, all PCPs, psychiatrists, chief nursing executive, clinical pharmacist, and the psychology director. The events of the past 24 hours were discussed, including hospital admissions, transfers, use of emergency drugs, and restraints. Minutes were recorded for this meeting. • Daily Unit Meetings – Although this was not a clinical meeting, information on medical issues was discussed. The dental appointment schedule for the day as well as the failed appointments from the prior day were also discussed and	

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		documented in the minutes. • Weekly Medical Review Committee – This meeting had the ability to greatly assist in fostering the delivery of integrated services. Discussions occurred among the medical staff, but also between medical, pharmacy, nursing, habilitation, and respiratory. Issues included adverse drug reactions, clinical interventions, physician orders, QDRRs, pretreatment sedation, and pneumonia review. • The monitoring team attended several committee meetings which brought together various disciplines to review clinical issues at the facility and promote the integration of services: o Pharmacy and Therapeutics Committee o Medication Variance Reduction Committee o Polypharmacy Oversight Committee o Desensitization Committee-This was a new multidisciplinary committee developed to address refusals and other behavioral issues associated with the dental clinic. Details related to the function and activities of these committees are provided throughout the report. • The dental clinic continued its daily summary that included failed appointments. As noted above, this information was forwarded the unit directors for discussion during the next day's unit meetings. • Quarterly Drug Regimen Reviews were completed by the clinical pharmacist and recommendations made to prescribers. • Integration of psychology and psychiatry was improving. Psychology and psychiatry began routine meetings to address ways of enhancing integration of clinical services, such as cohesive case formulations. There continued to be deficits with regard to establishing an evidence-base approach of determining the efficacy of the medication regimen (i.e., irrelevant data collection concerning psychiatric target symptoms). • There was collaboration between the records department and the facility's nutritionists in order to improve IPN documentation. The monitoring team also noted several areas in which there was a definite lack of integration: • Medical staff participation in the team process via required meetings was poor. As the content expert on the topic of medical issues and health care, the PCPs role is not only to provide medical care, but to provide information to the IDT on how the health status of the individual impacts well being, goal setting, opportunities, and barriers for the individual. It would be important for the primary provider to attend the annual planning meeting to discuss how the	

#	Provision	Assessment of Status	Compliance
		health status of the individual could impact opportunities for transitioning or achieving a personal goal set by the individual. The low compliance rate with meeting attendance was reported to represent an improvement in attendance. • Neurology-psychiatry – There was no evidence of integration of these disciplines. As discussed in sections J and L, the consulting neurologist was not aware of the requirements for integration. • Consultation referrals –The medical staff complied with the requirement to document agreement/disagreement in the IPN. In very few instances was there documentation of the decision to refer or not to refer the recommendations of consultants to the IDT. This is discussed in more detail in section G2. • Multidisciplinary clinical protocols were issued by state office. While the medical department moved forward on implementing some of the protocols, there were no notable efforts on the part of the facility to develop an overarching plan to ensure that all disciplines received adequate training on the content of all the protocols that were issued. This would be an important step in ensuring delivery of integrated services. • The PNMT did not have representation by all required disciplines at the time of this review. PNMT assessments that had been initiated in February 2012 were still incomplete at the time of the onsite review conducted by the monitoring team in September 2012. This was not acceptable and did not reflect appropriate integration of clinical services. • During the onsite review, the monitoring team attended the ISP meeting for Individual #151. The meeting was attended by the relevant clinical services. The IDT proceeded through the list of health risks and attempted to discuss and rate each risk one at a time, independent of other related health risks and relevant aspects of his life. In addition, at several points during the meeting, the representatives of the different clinical/programmatic entities who served Individual #151 failed to demonstrate the spirit of "integration," such as mixing, incorporating, combining, and assimilating the interventions of different clinical services/programs into a whole plan/program that was adequate and appropriate to meet Individual #151's needs. o For example, during the ISP meeting it was revealed that when Individual #151 was at his day program, he participated in structured activities that he enjoyed. Thus, he rarely, if ever made attempts to pull at his tracheostomy and/or gastrostomy tube. Since, for reasons unclear to the monitoring team, Individual #151 failed to have his preferred activities/items currently available to him on his home, it was suggested by a member of his IDT that, while waiting for more activities/items to be purchased, Individual #151's day program activities/items could be used on his home too. This observation, and	

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		others, suggested that the various clinical and program entities were more inclined to operate in silos rather than meet the needs of the individual and reduce the frequency and time he spent restrained by bilateral hand mitts. Overall, there was little forward movement in this area. Moreover, there was no organized approach to addressing, measuring/monitoring, or reporting on the facility's expectations, processes, and implementation of processes to provide clinical services to individuals in an integrated manner.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The facility made some progress with this provision item. A consult tracking log was implemented in recent months. In order to transfer information to the IDT, each provider was required to complete a form which stated agreement or disagreement with the recommendations as well as the need to refer the recommendations to the IDT for integration with existing supports. The sick call nurse was responsible for forwarding the form to the RN case manager who shared the information in the unit meetings. The monitoring team reviewed the August 2012 unit meeting minutes. There was evidence that some information was shared however, it was very brief and usually limited to the occurrence of the appointment. The small number of consults documented may have resulted from the decision not to refer to the IDT or from failure to complete the form. The facility implemented a database to track consults. The consults and IPNs for eight individuals were requested. A total of 48 consults completed after March 2012 (including those from the record sample) were reviewed: • 29 of 48 (60%) consultations were summarized by the medical providers in the IPN within five working days; all of the consults reviewed were initialed and dated by the medical providers indicating review of the consults. Providers usually documented in the IPN a summary of the recommendations of the consultants as well a statement related to agreement or disagreement with the recommendations. The form, which summarized the recommendations and addressed the need for IDT referral was found in very few of the records provided. The Settlement Agreement requires that medical providers review and document whether or not to adopt the recommendations and whether to refer the recommendations to the IDT for integration with existing supports. Facility policy mandates that this be completed within five working days.	Noncompliance

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		The monitoring team, therefore, recommends that IPN documentation include a statement regarding agreement or disagreement as well as the decision related to IDT referral. Clinically justifiable rationales should be provided when the recommendations are not implemented. It is further recommended that that the PCPs always notify the IDT when there is a disagreement with the recommendations of the consultant because further discussion may be warranted. The monitoring team also recommends that for every IPN entry, the medical provider indicate the type of consultation that is being addressed as well as the date of the consult (e.g., Surgery Consult, 1/1/12). This provision remains in noncompliance.	

Recommendations:

1. The facility should proceed with development of a local policy to guide this provision. The policy should outline the facility's approach to integration. It should also define the metrics that will be used to assess if integration is actually occurring. This will require creating measurable actions and outcomes (G1)

2. Departments providing clinical services should develop procedures or at least a statement/philosophy regarding the department's role in the provision of integrated services. Guidelines, philosophies, and procedures should be formally adopted and promoted within the departments. This task should not be confused with outlining job duties and responsibilities. (G1).

3. The medical director should determine why the consultation recommendation forms were not present in the records reviewed (G2).

4. Physicians must document consultations in the IPN and make a decision regarding the need to refer the recommendations to the IDT. This should be documented for all of the external consult (G2).

5. 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 Self-Assessment o MSSLC Provision Action Plan o MSSLC 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, 2012 Interviews and Meetings Held: o Dolores Erfe, MD, Medical Director o Angela Johnson, RN, Medical Compliance Nurse Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Psychiatry Clinics o Neurology Clinic o Daily Clinical Services Meetings
	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) the provision action information. For the self-assessment, the facility described for each of the seven provision items, several activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating The activities described, for the most part, did not reflect the core of the provision item. For provision H1, only medical assessments were listed, even though the provision clearly applies to all clinical disciplines. 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. 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 provision items. The monitoring team was in agreement.
	Summary of Monitor's Assessment: The facility made very little progress in this area. The medical director continued to serve as lead for this provision. A policy for the minimum common elements of clinical care, based on the draft state policy, was developed on 7/30/12. It remained in draft format at the time of the review. MSSLC did not have any centralized tracking of assessments. It was reported that the QA Department was assuming this responsibility. During discussions with the medical director, data were provided for medical and pharmacy assessments. Other clinical areas were not included. This report highlighted that assessments were problematic in several clinical areas. A set of clinical indicators was developed shortly before this review. Additional indicators are needed and indicators must be developed for all of the clinical services. Much of the work that needed to be done in this area will hinge on the development of a robust set of indicators that can be utilized across the continuum of treatment and evaluation of treatment.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	No measurable progress was seen in this area. The state office policy, which remained in draft, required <u>each department</u> to 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. During the discussions with the medical director and medical compliance nurse, they presented information on compliance with annual medical assessments, quarterly medical summaries, and QDRRs. There were no data presented in this meeting or in the self-assessment on the status of the assessments in other areas. The medical director reported QA would soon start tracking assessments. 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, and reviewed assessments and facility data. The results of those activities are summarized here: • For this review, the compliance for timely completion of Annual Medical	Noncompliance

#	Provision	Assessment of Status	Compliance
		Summaries was 95%. The facility reported 96% compliance for March 2012 through July 2012. Medical assessments are discussed in detail in section L1. • The completion of Quarterly Medical Summaries was inconsistent in the records reviewed. The facility reported 54% compliance for June 2012 through August 2012. • Quarterly Drug Regimen Reviews were completed in a timely manner and were significantly improved as detailed in section N2. • A significant improvement was noted in the compliance with comprehensive dental assessments. The compliance rate for the reporting period was 97%. • Regularly scheduled quarterly and annual nursing assessments were present in all but two of the 26 sample individuals' records. This was a significant improvement from the findings of prior reviews. Although there were some improvement in some areas of the nursing assessments, assessments failed to provide one or more components of a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions to achieve desired health outcomes. • The need for a PNMT assessment suggests that there is a significant degree of urgency to provide adjunct supports to those provided by the IDT. A number of assessments initiated in February 2012 were still incomplete as of September 2012. • There was a lack of timeliness in the completion of QPMRs noted in 74 out of 259 (29%) where individuals were not evaluated by a psychiatrist within a 90-day period ranging from 3/8/12 to 9/8/12. • The facility had 34 individuals who still required a comprehensive psychiatric assessment as described in Appendix B.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The medical director reported that data were insufficient to determine compliance with this requirement. 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. However, some documents, such as QDRRs, frequently did not use ICD nomenclature when listing the indications for medications. Diagnoses, such as sleep and allergies, were utilized. • There was an improvement in this section with the implementation of the electronic QPMRs. Over the course of the visit, the monitoring team observed the psychiatrist reference the form that allowed for documentation for the previous diagnosis and the current diagnosis. Additionally, although variable, some records revealed documentation of specific criteria exhibited by an individual indicating a particular DSM-IV-TR diagnosis. • Across the majority of the 26 sample individuals' reviewed, the conclusions (i.e.,	Noncompliance

#	Provision	Assessment of Status	Compliance
		nursing diagnoses) drawn from the assessments failed to capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks	
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.	A set of clinical indicators was developed a few weeks prior to the compliance review. Indicators were developed for UTIs, osteoporosis, diabetes mellitus, aspiration pneumonia, constipation, and seizure disorder. The multidisciplinary protocols and various guidelines should be utilized to expand the set of indicators including those that can be used in a practical manner on a daily basis to assess response to treatment. For the self-assessment, the medical director reviewed clinical interventions, review of physician orders, and polypharmacy data to help determine compliance with this provision item. The conclusion was that the facility was in noncompliance. The department did not submit nor present any data on the timeliness and appropriateness of treatment for medical issues. The monitoring team noted the following through observations and record reviews: • The absence of complete nursing diagnoses was a serious problem because the HMPs, and the selection of interventions to achieve outcomes, were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. Thus, the majority of the individuals reviewed failed to have HMPs that referenced specific, individualized nursing interventions developed to address all of their care needs, including their needs associated with their health risks. Of note, the process of health care planning was slated to change. o At the time of the review, MSSLC had not yet begun its implementation of the state's integrated health care planning process. • The timeliness of the clinic consultations was outlined in H1. There are examples provided in section J regarding medications ordered for an individual when not warranted due to an absence of an adequate indication. The facility utilized polypharmacy and was guarded when the topic of minimizing the use of numerous agents was discussed. The psychiatrists stated that individuals required medication for aggression towards others and SIB, but were not focused on psychiatric symptoms associated with DSM-IV-TR diagnostics. • Generally, for the records reviewed, the monitoring team noted that management of medical problems, such as osteoporosis, was appropriate. The facility encountered difficulty is maintaining the data to demonstrate this. Although information on pneumonia management was limited, it was noted that the medical staff were making changes in treatment plans based on assessments and responses to treatment.	Noncompliance

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H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	As discussed in section H3, the facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines. Many of the clinical management staff appeared to be confused regarding what was meant by clinical indicators. The monitoring team attempted to clarify this during the onsite review and during the exit presentation. The confusion seemed to be an incorrect interpretation by the facility that clinical indicators referred to signs and symptoms of diseases and conditions that direct support professionals were to be competent to identify. That is not the case. Clinical indicators assess health structures, processes, and outcomes. They provide a quantitative basis for quality improvement, or identifying incidents of care that trigger further investigation. Indicators can be generic measures that are relevant for most individuals or disease-specific, expressing the quality of care for individuals with specific diagnoses. Monitoring health care quality is impossible without the use of clinical indicators. Specific examples related to clinical indicators include: • Across all records reviewed, the clinical justification for the goals/indicators of the efficacy of treatments were unclear. For example, some individuals had goals that indicated that they would suffer less untoward outcome(s) than they suffered over the past year, and most individuals had goals that indicated that they would not suffer an untoward outcome over the next year. • The monitoring team attended one individual's ISP meeting where components of the individual's risk assessments/risk action plans were reviewed. It was clear that the individuals' team would continue to benefit from additional training and support regarding outcome identification, measurement, and evaluation. • The collaboration between psychology and psychiatry regarding the selection of clinical indicators focused predominantly on maladaptive behaviors as opposed to evidence-based reasons to determine the efficacy of the medication. Polypharmacy will not be successfully minimized if medications are only prescribed for behavioral challenges that may have been the result of environmental antecedents as opposed to symptoms of a psychiatric disorder. • As described in Section P, the OT and PT treatment interventions did have associated measurable objectives. The inconsistency of documentation, however, did not reflect routine review of status or progress specifically related to the goals and progress. In a number of cases, the justification for changes, holding, or terminating the interventions were not well documented (e.g., Individual #449, Individual #557, Individual #353).	Noncompliance

#	Provision	Assessment of Status	Compliance
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 developed clinical indicators for six medical conditions as discussed in section H3. This occurred a few weeks prior to the compliance review, so little additional work was done in this area. The need to develop a medical quality program remained outstanding. As of the review, there were no systems for effectively monitoring the health status of individuals that were being consistently implemented at MSSLC. Although the nursing assessment process vis a vis acute, quarterly, and annual assessments, would/could serve as such a system, there was no evidence that it was implemented, partially or otherwise. Thus, health plans (acute and chronic), which were in place for days, weeks, months, and even years, were not adequately reviewed/revised and modified to meet the individuals' needs and the changes in their health status and risks. Developing a comprehensive format to monitor health status will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The facility will need to expand the set of clinical indicators to define what is important to the individuals and what is important that the facility monitor. The facility should utilize, but not limit itself, the clinical protocols in the development of additional indicators.	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.	The medical department established a set of indicators, but additional indicators were needed. Medical providers can use these indicators in daily practice through various assessments to determine if treatment is effective for an individual. Once established, the facility's quality program would assess the care of particular individuals who crossed the threshold for review and would also look at overall aggregate data. Observations by the monitoring team during this review included: • There was little evidence that changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes resulted in revisions to their HMPs. For example, individuals with plans to address risk for alteration in skin integrity were not modified in response to episodes of skin breakdown, individuals with plans to address their risk for injury related to falls were not modified despite falls with injuries, individuals with plans to address an acute head injury were not modified to address repetitive head injuries, and individuals with plans to address the risk of side effects of their medications, especially psychotropic medications, were not modified in response to episodes of adverse reaction(s) to medication(s). • As previously noted, this type of modification response was not routinely followed, except for an increase in medication to target behavioral challenges.	Noncompliance

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H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	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.	Noncompliance

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. This data must be managed in a centralized location such as the QA Department.
    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. Correct nomenclature should be used for all documentation including medication indications (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).

6. State office should provide additional guidance to MSSLC on this provision. Finalization of state policy should be helpful to the facility (H7).

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o DADS SSLC Risk Guidelines dated 4/17/12 o List of individuals seen in the ER in the past year o List of individuals hospitalized in the past year o List of all choking incidents o List of individual at risk for aspiration o List of individuals with pneumonia incidents in the past 12 months o List of individuals at risk for respiratory issues o List of individual with contractures o List of individual with GERD o List of individuals at risk for choking o Individuals with a diagnosis of dysphagia o List of individuals at risk for falls o List of individuals at risk for weight issues o List of individuals at risk for skin breakdown o List of individuals at risk for harm to self or others o List of individuals at risk for constipation o List of individuals with a pica diagnosis o List of individual at risk for metabolic syndrome o List of individuals at risk for seizures o List of individuals at risk for osteoporosis o List of individuals at risk for dehydration o List of individuals who are non-ambulatory o List of individual who need mealtime assistance o List of individuals at risk for dental issues o List of individual receiving enteral feedings. o List of individuals with chronic pain. 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 Risk Rating Forms and Action Plans for • Individual #80, Individual #446, Individual #152, Individual #161, and Individual #436 o ISPs, Risk Rating Forms, Risk Action Plans for: • Individual #157, Individual #287, Individual #325, Individual #451, and Individual #451

	Interviews and Meetings Held: o Informal interviews with various DSPs, program supervisors, and QDDPs in homes and day sites Pat Samuels, Incident Management Coordinator o Charlotte Kimmel, PhD, Director of Psychology o Alynn Mitchell, Acting QDDP Coordinator o Norris Buchmeyer, CNE o Gabrielle Brewer, Infection Control Nurse o Joy Lovelace, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 9/24/12 and 9/26/12 o ISP preparation meeting for Individual #94 and Individual #441 o Annual IDT Meeting for Individual #151 o Shamrock PIT Meeting 9/26/12 o Longhorn PIT Meeting 9/27/12 o Restraint Reduction Committee Meeting 9/27/12 o Quarterly QAQI Council Meeting
	Facility Self-Assessment: MSSLC submitted its self-assessment. It was updated on 9/6/12. Along with the self-assessment, the facility had two others documents that addressed progress towards meeting requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement and one 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 similar activities implemented by the monitoring team to assess compliance. A sample of risk assessments was reviewed using the statewide section I audit tool. In conjunction with the section I audit tool, the facility looked at other relevant activities related to the risk assessment process. This included attendance at training provided on clinical indicators, QDDP monthly reviews, observation of ISP risk discussions, individualized training on risk indicators provided to DSPs, and availability of risk action plans to DSPs. Findings from the facility self-assessment were similar to findings by the monitoring team. The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed. As the facility gains a better understanding of the risk process, it will be important for the audit process to evaluate quality and efficacy of risk assessments and plans.

	Summary of Monitor's Assessment: While progress had been made on meeting compliance through an initial attempt to ensure all individuals were accurately assessed and action plans were in place to address risks, the facility was not yet in compliance with the three provisions in section I. Adequate plans were not in place to address all risks identified. Risk action plans were not being consistently reviewed and monitored. Since the last review, the state office had made revisions to the At-Risk Individuals policy. Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually. Key department heads from MSSLC recently attended training in Austin on the new risk process. Consultants from the state office will be providing additional training to IDTs at MSSLC in the near future. As noted in section F, assessments were not being consistently completed prior to ISP meetings. Teams could not adequately discuss risk factors without current, accurate assessments in place. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs. Teams were waiting until a critical incident occurred before aggressively addressing the risk. Plans should be implemented immediately when individuals are at risk for harm.

#	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 an integrated health care 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. Since the last review, the state office had made revisions to the At-Risk Individuals policy. Changes included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related (regarding outcomes or provision of services and supports) were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same	Noncompliance

#	Provision	Assessment of Status	Compliance
		grouping sequence as the Risk Guidelines. Seven groupings of risk categories were identified. The template of the draft Integrated Risk Rating Form included bulleted items to be addressed for each risk factor, including: data, supports, baseline, discussion and analysis/need for new supports, rationale/risk rating, triggers, and criteria for IDT review. Updates in status were to be noted on the form, making it easier to track status and determine when the team had met to discuss changes in status. The Risk Action Plans for the identified high and medium risk indicators were to be replaced with Integrated Health Care Plans (IHCP) designed to provide a comprehensive plan that will be completed annually and updated as needed. The state office hired a team of consultants to work with facilities on developing person-centered support plans. This was to include a risk identification process that would result in one comprehensive plan to address all support needs identified by the IDT. The risk identification process had undergone several revisions in the past year. The consultants had not yet provided training and technical assistance to MSSLC on the latest revisions in the risk process. The monitoring team was able to observe one IDT meeting using the new style ISP format and new risk rating forms. The team had not yet been formally trained on the new process, but did attempt to follow prompts from the newly created IRRF. At the ISP meeting observed for Individual #151, all disciplines contributed to the risk discussion and held a much more integrated discussion of risks. His physician, who briefly attended the meeting, provided the IDT members with a summary of Individual #151's medical status over the past year, which included bouts of aspiration pneumonia, weight loss, tracheostomy, colonoscopy, and hospitalizations.. After Individual #151's physician presented his summary, due to a scheduling conflict, he was unable to stay for the IDT's review of Individual #151's health risks and needs. The IDT then proceeded to discuss and rate each risk one at a time and apart from discussion regarding his preferences. During the meeting, some IDT members participated much more than others. The team did not consider all important criteria when assigning risk ratings and did not have all needed information. For example, there were questions regarding a recent gastrointestinal assessment, family history, and medication changes that could have impacted consideration of his risks in a number of areas. This information was not available to the team. There was still heavy reliance on the risk guidelines developed by the state to assign risk ratings without consideration of how risk factors were interrelated. The facility is to be commended for a greater focus on risk factors and their attempt to integrate discussion.	

#	Provision	Assessment of Status	Compliance
		At the third quarter ISP preparation meeting held for Individual #94, the IDT reviewed his risk ratings. The discussion was led by the nurse with very little input from other relevant team members. She read off each risk area, compared criteria with the risk guidelines and suggested a rating of high, medium, or low for each risk area. The team focused on the number of critical incidents that had occurred over the past year rather than his risk for a critical incident occurring. He had five falls over the past year, but since only one resulted in a serious incident, the nurse recommended a medium risk rating. His diagnosis of osteopenia was not considered in rating the seriousness of his risk for falls. Similarly, the team agreed to assign a medium risk rating for seizures because he had only had five seizures over the past year. The nurse also recommended a medium risk for ear infections, since he had two over the past year. The team did not discuss how seizures or ear infections might impact his risks for falls and injuries. His last physical and list of current medications was not available for review by the team. Both of these were important documents that should have been available for review prior to a discussion regarding risks. At a second ISP preparation meeting observed for Individual #441, risks ratings were not reviewed in depth. The facility will need to establish standard procedures for reviewing risks, determining risk ratings, and developing action plans to address risks. A review of a sample of risk rating forms indicated that all risks still were not accurately being identified, even though IDTs were doing a better job of including risk criteria on the risk rating form. For example, • Individual #152's Risk Rating Form indicated that the team had rated him as low risk for diabetes, even though the rationale stated that he had a past diagnosis of pre-diabetic, he was significantly overweight, and had a family history of diabetes. • Individual #161's IDT rated his risk for choking as low. He had a diagnosis of dysphagia requiring a pureed diet and honey thick liquids. He was also considered low risk for skin integrity even though he was both non-ambulatory and incontinent. DSPs had recently been trained on recognizing and documenting clinical indicators of risk. Daily observation notes now included an area for DSPs to list risk areas rated as high or medium for individuals whom they were assigned to support. They were to identify any symptoms or clinical indicators that might signify a change in status. A review of individual notebooks in the homes and day programs revealed that risk ratings and risk action plans were not consistently being filed in notebooks. ISPs did not summarize the risk action plans, but instead, referred the reader to the plan. QDDPs will need to ensure that all supports needed are integrated into one comprehensive plan (the ISP). The ISP should be accessible and offer clear guidance to all staff on providing	

#	Provision	Assessment of Status	Compliance
		supports throughout the person's day. All supports should be frequently monitored and revised when the desired outcome is not achieved. The state policy required that all relevant assessments were submitted at least 10 days prior to the annual ISP meeting and accessible to all team members for review. As noted in section F, all disciplines were not routinely completing assessments prior to annual ISP meetings or attending ISP meetings. The facility had begun using a database to track submission of assessments by discipline and attendance at IDT meetings. These databases will be useful when the facility begins consistently collecting and analyzing data. As noted in section F, the submission of assessments and attendance at IDT meetings was a barrier to accurately identifying risks and support needs for individuals. 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). • Ensure that assessments are updated and submitted prior to annual ISP meetings and all relevant disciplines attend meetings and participate in discussions regarding risks. • Consider and 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 frequently so that plans can be revised if progress is not being made or regression occurs. • Ensure that data collected regarding incidents and injuries is frequently analyzed for indication that supports may not be adequate for safeguarding individuals. A noncompliance rating was assigned to I1 in the facility self-assessment. The monitoring team agreed with this assessment.	

#	Provision	Assessment of Status	Compliance
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	As noted throughout this report, it was still not evident that all risks were appropriately identified by the IDT. The facility will have to have a system in place to accurately identify risks before achieving substantial compliance with I2. Additionally, there continued to be problems with health risk ratings that were not consistently revised when significant changes in individuals' health status and needs occurred. A sample of records was reviewed to determine if changes in circumstance should have resulted in an assessment of current services and support, risk ratings, and/or plan revisions. Results of section M monitoring revealed improvement in the facility's conduct of timely risk assessment and planning meetings after individuals' discharge from the hospital. Although it appeared that teams were usually meeting immediately following a critical incident, it was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time. For example, • Individual #436's IDT had met numerous times regarding behavioral incidents. On 4/27/12, the IDT requested a review of missed doses of medication. The nurse was assigned to complete the review and report back to the team. The team met again six days later. A review of medication was not reported to the team. It was not clear if the assessment was ever completed. On 7/19/12, his IDT met following a series of incidents resulting in restraint. His BCBA recommended a speech consultation. ISPAs held to address continued aggression and restraint incidents dated 8/13/12 and 8/16/12 noted that the speech consultation was still pending. • Individual #80's speech assessment recommended an updated swallow study on 2/27/12. Her Risk Action Plan dated 3/20/12 indicated that she was still waiting for an appointment to be scheduled. Her Risk Action Plan was revised on 8/1/12, but did not include recommendations (if any) made from the new swallow study. Of the 26 sample individuals for section M whose records were reviewed, more than half 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. See section M for additional comments and examples regarding the risk assessment process. The facility self- assessment indicated the process to ensure timely completion and implementation of action plans needs to be refined to meet substantial compliance with I2. The facility was not yet in compliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 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, plans were in place to address all risks for those individuals designated as high risk or medium risk in specific areas. The CNE reported that individuals would be assessed and action plans developed using IRRF and IHCP as annual ISP meetings were held. As noted throughout this report, it was not evident that risks were being appropriately identified and action plans developed to support all risks. Action plans that were in place were not yet being integrated into the ISP. The facility had made some progress in regards to developing clinical indicators to be monitored, but it was not evident that consistent monitoring of those indicators was occurring. ISPAs were used to document initial discussion when a change in status was identified. There was not always documentation of follow-up when recommendations were made by the IDT. IDTs were not consistently addressing risk prior to the occurrence of a critical incident. For example, • Individual #157's IDT rated him as medium risk for weight gain because he was overweight at 208 pounds at the time of his risk assessment in April 2012. His risk action plan noted that the nurse would monitor his weight. QDDP monthly reviews noted that data was not available for his weight in May 2012. In June 2012, he had gained 13 pounds. There was no documentation that the team had met to review this additional weight gain. In July 2012 he had gained another pound. Again, the IDT had not met to review his risk action plan or discuss the weight gain. • Individual #451 was at medium risk for cardiac issues and fluid imbalance. He had an action step to address this risk by monitoring his blood pressure. The QDDP monthly reviews did not include a review of his blood pressure or note that an HCP had been developed to address this 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 agreed with that assessment.	Noncompliance

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. Ensure attendance or at least input by all relevant team members in the risk process (U1)
4. 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).
5. Ensure IDTs are monitoring progress on health and behavioral outcomes and plans are revised when necessary (12).
6. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk (I2).
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 IDT 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 Auditing/monitoring data and/or reports addressing the pretreatment sedation medication o A description of any current process by which individuals receiving pretreatment sedation were evaluated for any needed mental health services beyond desensitization protocols o 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 Documentation of inservice training for facility nursing staff regarding administration of MOSES and DISCUS examinations o Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS scores, with dates of completion for the last six months 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 has been designated as the facility's lead psychiatrist o CVs of all psychiatrists who work in psychiatry, including any special training such as forensics, disabilities, etc. o Overview of psychiatrist's weekly schedule o Description of administrative support offered to the psychiatrists o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility o A list of continuing medical education activities attended by medical and psychiatry staff o A list of educational lectures and 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 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 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 All data presented, doctor's orders, and Dr. Kirby's documentation for psychiatry clinic, 9/27/12 regarding Individual #68, and Individual #157 o All data presented, doctor's orders, and Dr. Rao's documentation for psychiatry clinic, 9/27/12 regarding Individual #366, and Individual #429 o All data presented, doctor's orders, and Dr. Cowens' documentation for neuropsychiatry clinic, 9/24/12 regarding Individual #934, Individual #57, and Individual #192 o These following documents for all of the individuals listed in the above four bullets and for Individual #177, Individual #550, Individual #934, Individual #133, Individual #539, Individual #441, Individual #589, and Individual #639 • 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 o Ten Quarterly Psychiatric Medication Reviews (QPMRs) in the new electronic format for the following individuals: Individual #30, Individual #169, Individual #106, Individual #434, Individual #535, • Individual #235, Individual #156, Individual #436, Individual #543, and Individual #70 o IPNs generated from scan call consults with the child psychiatrist <u>Interviews and Meetings Held</u>: o Dolores Erfe, M.D., Medical Director o Kendall P. Brown, M.D., Lead Psychiatrist o Charlotte M. Kimmel, Ph.D., Director of Psychology o Anyssa Garza, Pharm.D., Pharmacy Director o Ms. Virginia Jackson, psychiatry assistant o Ms. Bobbie Hall, psychiatry assistant <u>Observations Conducted</u>: o Psychiatry clinic conducted by Juanita Kirby, M.D. o Psychiatry clinic conducted by Madhu Rao, M.D. o Neuropsychiatry Clinic with Kevin E. Cowens, Sr., M.D. and Juanita Kirby, M.D. o Neuropsychiatry Clinic with Kevin E. Cowens, Sr., M.D. and Kendall P. Brown, M.D. o Behavior Therapy Committee (BTC) meeting o Clinical Services meeting o Pharmacy and Therapeutics (P&T) Committee meeting o Desensitization Committee meeting with John Sponenberg, D.D.S., facility dentist o Preferences and Strengths Inventory (PSI) for Individual #441 o Polypharmacy Meeting o Staff Meeting with Chesapeake Consulting Group and MSSLC staff
	Facility Self-Assessment: MSSLC submitted the self-assessment. MSSLC continued to struggle with understanding the purpose of the self-assessment. The self -rating category for the majority of the provisions in section J said "based on the findings from this assessment, since not all activities to assess compliance have been initiated, data is insufficient to reflect substantial compliance." For the self-assessment, however, the facility was instructed to describe 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 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 looked at. • For example, in J1, the facility noted that activities engaged in to conduct the self-assessment consisted of "record reviews of licensed psychiatric clinical staff." Record reviews, however, were

not pertinent to J1. The monitoring team did not understand the term "licensed" in regards to psychiatric staff. The facility should have focused on information, such as specialization in child and adolescent psychiatry, board status, experience in regards to working with individuals with developmental disabilities, (with further confirmation outlined in the psychiatrist's curriculum vitae and upon interview of the psychiatric staff).

- Furthermore, pertinent up to date information such as the lack of services by a child and adolescent psychiatrist at MSSLC were not cited in the facility self-assessment. Thus the facility inappropriately rated substantial compliance for J1 when the lack of persons who are qualified professionals for the treatment of minors at MSSLC warranted a rating of noncompliance. During the onsite visit the psychiatry department agreed with the monitoring team's assignment of noncompliance of J1 and planned to cite such essential information in future self-assessments.

The self-assessment for J13 did not provide detailed information about the frequency of consultation with the psychiatrist. The psychiatric assistants maintained a database of clinical contacts, but the facility did not utilize the data to calculate the number and percentage of individual, who did not receive timely psychiatric consultation.

The facility provided information for the self-assessment by electing to follow the outline in the psychiatric care and services monitoring tool for provision J. The monitoring team does not follow the outline of this tool for this provision and, furthermore, everything did not require a tool. For example, for J6, implementation of procedures for psychiatric assessment, diagnosis, and case formulation, as described in Appendix B, the self-assessment did not list the following items that were deemed by the monitoring team as vital in the determination of compliance for this section:

- the number of evaluations that were completed;
- the average number of assessments completed per month since the last visit;
- the percentage of evaluations completed;
- the remainder of Appendix B evaluations not done;
- average number of new admissions every month since the last review period requiring an Appendix B
- assessment.

Instead, the facility focused on a sample review of six cases, for the period from 2/1/12 to 7/31/12, to determine the percentage of individuals in MSSLC who are receiving psychiatric care, and had an evaluation completed as per Appendix B format.

Even though more work was needed, the monitoring team wants to acknowledge the efforts of the psychiatric assistants in gathering pertinent information and data for the clinicians to review and assign a precise self-rating.

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 lead psychiatrist and medical director self-rated the facility as being in

	substantial compliance for only one provision item (J1). To take this process forward, the monitoring team recommends the psychiatry department to 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. • The next step is for the lead psychiatrist to model the report produced by the monitoring team for this provision in order to include everything in the self-assessment that the monitoring team reviews. This can be done by going through the monitoring team's report, paragraph by paragraph, and including all of those topics in the self-assessment. • It will be important for the self-assessment to line up with the topics in the monitoring team's reports. The self-assessment listed the activities engaged in to conduct the self-assessment for each provision in J of the Settlement Agreement and these should be consistent with the monitoring team. The second document, detailing the action steps, was 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).
	Summary of Monitor's Assessment: MSSLC was in noncompliance for all 15 sections of provision J of the Settlement Agreement. The department designated a full time lead psychiatrist, however, the facility continued to experience difficulty with the recruitment of other full time psychiatrists, and had inconsistent locum tenens psychiatric staffing. The role of the lead psychiatrist was not clear to the monitoring team. Normally, this individual implemented policy and procedure that included documentation requirements geared toward meeting generally accepted professional standards of care in psychiatry. There had been challenges for the lead psychiatrist and the psychiatric department in the intervening period since the last monitoring review due to a turnover in the psychiatric clinic staff. This included the child, forensic, and general psychiatrist no longer providing consultative services to the facility that served minors with complex psychiatric conditions, substance use problems, in addition to forensic issues. Thus, the facility no longer met substantial compliance in J1 this review period. 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 different departments must communicate with one another to allow for appropriate assessment and intervention to take place by the IDT. 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 reliably 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 evaluation, case formulation, diagnosis, and justification for treatment with medication remained insufficient facility-wide. The completion of psychiatric assessments, both quarterly and Appendix B comprehensive evaluations, had progressed, but more work was needed. The monitoring team calculated that 87% of the evaluations, as described in Appendix B, had been completed with a remainder of 34 individuals in need of a comprehensive assessment. During the onsite observation of the psychiatric clinics, the psychiatrists informed the monitoring team of what they considered to be a tedious exercise to type the information into an electronic QPMR form. Further, during one of the clinics, even when the IDT articulated that an individual did not have an accurate diagnosis and did not have an appropriate indication to continue the medication, the psychiatrist proceeded with giving the individual medication, did not amend the documentation, and did not correct the diagnosis because of the paperwork task. This type of approach to the treatment of individuals at MSSLC was alarming and did not meet generally accepted professional standards of care in psychiatry. The monitoring team was concerned that, if the psychiatrist and the IDT exhibited this type of unprofessional conduct in the presence of the monitoring team during the onsite observation, it was foreseeable that the provision regarding the delivery of psychiatric services would continue to be substandard. The practice at MSSLC appeared to be based, at least in part, upon a view that individuals who were prescribed numerous medications should continue to receive all of the medications in fear of an exacerbation of behavioral challenges. If the individual was doing well, and if there were no established reasons to continue every one of the medications, the team did not routinely attempt to slowly decrease one of the medications and then collect further relevant information. This type of practice pattern hindered the IDT from thoroughly reviewing the individual's history, including the utilization and efficacy of the psychotropic medication, and has resulted in an insufficient assignment of the differential diagnoses. There was noted progress via the development of a desensitization committee attended by numerous staff from various disciplines, including but not limited to dental, psychology, and psychiatry. The facility needs to be cognizant of all the offsite pretreatment sedation details and the potential effects of the medication administered to the individual, even if received at another facility. There were no pretreatment medications administered at MSSLC, but this did not absolve the facility of its responsibility to monitor individuals who have received pretreatment sedation elsewhere and then returned to MSSLC. The facility did not administer a Reiss screen for a change in status. There should be a rescreen if there is a change in status. If the screen so indicated, a comprehensive psychiatric assessment and diagnosis (if warranted) was to be attained in a clinically justifiable manner. The pharmacy department provided updated information, including the number of individuals classified as receiving a polypharmacy regimen and the total number of individuals that were actually prescribed

	psychotropic medication. Facility-level data included 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, but the facility continued to struggle with the elimination of medications that were not clinically justified. This justification must be reviewed at a facility level review meeting. A database was designed to track the administration dates and scores of the MOSES and DISCUS. The facility must calculate its own percentage of individuals that were examined in a timely fashion and report these findings in the facility self-assessment. The psychiatry department 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 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 and followed through with proper clinical intervention. For about half of the cases, follow-up consultations were conducted frequently throughout the period from 3/8/12 to 9/8/12. In fact, individuals were evaluated up to six times during this time period by the psychiatrist. This was notable of advancement being made in this section. There were onsite neuropsychiatric clinics that took place at MSSLC since last review and during the week of the onsite visit. The neurologist informed the monitoring team that it was not necessary for the psychiatrist to be present during the clinic and would speak with the psychiatrist at the end of the consultation. The neurologist was unaware of the Settlement Agreement (J15) that required the facility to ensure that the neurologist and psychiatrist coordinate the use medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder. Unfortunately, the solo approach of the neurologist (e.g., not working through the IDT process) defeated the whole purpose of the neuropsychiatric consultation. There remained an inconsistent identification of indications and target symptoms for the AED regimen.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Qualifications The board certified child and adolescent, forensic, and general psychiatrist no longer provided consultative services to MSSLC, however, MSSLC continued to provide services to minors. The remaining three psychiatrists at the facility were either board certified or board eligible in general psychiatry by the American Board of Psychiatry and Neurology. Furthermore, the lead psychiatrist was also board certified in geriatric psychiatry. The detail of board status was not consistently listed in the psychiatrists' vitae. For example, one of the psychiatrists listed postgraduate training, but did not cite board status in psychiatry. This provision requires the facility to provide psychiatric services only by persons who are qualified professionals, therefore, this information should be documented.	Noncompliance

#	Provision	Assessment of Status	Compliance
		During the previous review, the monitoring team noted that it would be necessary for the child psychiatrist to routinely review the identified individuals' care, with the general psychiatric staff, particularly for youth under the age of 14, prescribed polypharmacy with complex psychiatric conditions, and/or involved in the judicial system. The monitoring team recommended that interaction with the individual and the child psychiatrist sometimes occur onsite at the facility and/or via telemedicine consultation as opposed to all contact being performed by phone. However, the last consultation provided by a board certified child and adolescent, forensic, and general psychiatrist occurred on 6/5/12, that is, three months prior to this review. <u>Experience</u> The lead psychiatrist, Kendall P. Brown, M.D., was board certified in general and geriatric psychiatry by the American Board of Psychiatry and Neurology. Dr. Brown noted that he had residency rotations where he learned about treating those with developmental disability during both his general and geriatric psychiatry training. Dr. Brown also listed prior experience with caring for individuals with developmental disability from 2009 to 2010 in Behar and Dallas Counties. Dr. Juanita Kirby was a board certified psychiatrist and had numerous years of experience in the field of psychiatry. She provided care for individuals with developmental disabilities in her practice. Dr. Kirby served in a directorship capacity for the Dallas County Mental Health and Mental Retardation division. She had been working at MSSLC since March 2012 through a locum tenens assignment. Madhu Rao, M.D., re-certified in general psychiatry in 2006. She completed her psychiatry residency at Griffin Memorial and University of Oklahoma in 1986. Dr. Rao's resume noted board certification in general psychiatry in 1996. She treated children and adolescents for 25 years with experience of providing care for several individuals with developmental disabilities. <u>Monitoring Team's Compliance Rating</u> The medical director and the lead psychiatrist acknowledged during the onsite visit that this section, J1, no longer met substantial compliance. Although the facility's self-assessment noted that the facility was in substantial compliance, it failed to outline the aforementioned problems (i.e., lack of access to a child psychiatrist for a facility that provides services to minors). Psychiatry staffing, administrative support, and the determination of the required FTEs are addressed below in section J5.	

#	Provision	Assessment of Status	Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Number of Individuals Evaluated At MSSLC, 259 of the 369 individuals (70%) received psychopharmacologic intervention at the time of the onsite review. The percentage of individuals receiving psychotropic medication was consistent with the previous review. Tracking Diagnoses and Updates No new policies or guidelines were developed since the last review. However, upon interview with the psychiatry assistants, it was reported that the psychiatry department had made strides to address the accurate tracking and monitoring of diagnoses. This was good to see because during the previous review, the facility did not have an organized system to manage and track diagnoses and diagnostic updates. Bobbie Hall, the psychiatry assistant, informed the monitoring team that the process bulleted below was implemented since the last review. The psychiatry department began utilizing an electronic QPMR form to solve the problem of illegible handwritten notes. It was reported that since 7/12/12, approximately 200 QPMRs have been completed using this revised, electronic form. • The psychiatrist was responsible for completing the electronic form and submitting it to the psychiatry assistant along with the psychology, nursing, and QDDP portion of the QPMR packet. • The psychiatry assistant then compared the QPMR form, HLT-99 (nursing form), and the master bill to ensure that all diagnoses matched across these documents. • The QPMR form was then used to update the Axis I and Axis II diagnoses in the Avatar database, the polypharmacy agenda, the VII.9 spreadsheet (i.e., a list of individuals prescribed psychotropic/psychiatric medication), and the VII.40 spreadsheet (i.e., a list of any individuals for whom the psychiatric diagnoses had been revised). • This was reported to be done on a daily basis after the QPMRs were held and the paperwork turned in by the psychiatrist. While the facility is commended for implementing this process, the monitoring team recommends formalization in an updated policy and procedure. The current MSSLC policy and procedure for psychiatry clinics (i.e., Medical 19) dated 8/28/11 stated that the psychiatrist was responsible for filling out and completing the master bill for each scheduled individual and submitting it back to the psychiatry assistant within 24 hours and for completing the QPMR form and submitting it to the "Program Tech for filing." This policy, however, did not correctly outline the current process. Additionally, while the psychiatry assistant reported that this process was done on a daily basis, the medical director stated during the previous onsite visit that the psychiatry assistants would be required to update their diagnostic tracking system only monthly. Furthermore, it was evident that the medical director was unaware of the details of this new tracking process, stating that the diagnostic updates were based solely from the master bill. These	Noncompliance

#	Provision	Assessment of Status	Compliance
		discrepancies regarding the new process will result in a disorganized tracking system of facility-wide data, affecting the consistency of diagnostics across disciplines. <u>Evaluation and Diagnosis Procedures</u> Upon observation of several psychiatry clinics, it was apparent that the team members attending the visit were well meaning and interested in the treatment of the individual. During the clinic, the psychiatrists also told the monitoring team about how challenging it was to complete the necessary forms and documentation. Since the prior monitoring review, however, the forms were supposed to be completed electronically instead of handwritten notation. The facility designed 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. Even so, some of the psychiatrists clearly had difficulty multitasking (e.g., managing the clinic, reviewing the data presented, typing the information received). This process needs to be further reviewed to provide staff support to the psychiatrists during the clinic to accomplish these tasks in a reasonable amount of time. The content of the new format of the electronic QPMR is discussed in J13. The new electronic form had a space for the previous and current diagnoses that was designed to address the discrepancy in psychiatric diagnoses across different disciplines' evaluations (e.g., PBSP, physician's annual medical review, ISP). These evaluation and diagnostic procedures provided the IDT and the facility a means of determining details of diagnostics or revision of diagnostics. This was also good to see. The following comments were from a review of the record of Individual #539. The frequency of contact dates by the psychiatrist included 2/16/12 (follow-up), 3/20/12 QPMR, and 4/17/12 (follow-up). He had not been seen by the psychiatrist since April 2012, that is, five months since the last evaluation. This was typical of other individuals' data regarding frequency of contacts. The monitoring team requested the psychiatry section for the last six months including Appendix B for this review. The initial psychiatric evaluation was dated 7/26/10 with diagnoses including post traumatic stress disorder (PTSD), conduct disorder, physical and sexual abuse of a child, and mild mental retardation. The active problem list dated 12/1/11 noted additional diagnoses, including ADHD, lipid abnormalities, increased glucose levels x 2, exogenous obesity, and nocturnal enuresis. There was a line through conduct disorder (resolved 6/28/11). • The consent for the psychotropic medication, Zyprexa, dated 2/15/12 noted the indication for the medication was bipolar disorder, but he did not have this condition. • The comprehensive nursing assessment for time period 6/22/12-9/22/12 noted that the Zyprexa was for PTSD.	

#	Provision	Assessment of Status	Compliance
		This example highlighted typical problems with the process used at MSSLC for evaluation, diagnosis, and treatment recommendations. There was inadequate justification of the selection of an agent, such as Zyprexa. Furthermore, Individual #539 had several medical problems, but continued to receive a medication known to produce side effects, such as weight gain, hyperlipidemia, and elevated glucose levels. <u>Clinical Justification</u> A review of a sample of 17 records revealed varying quality in documentation for the psychiatric reviews. The Quarterly Psychotropic Medication Review Form was a good attempt by the facility to streamline the documentation. It allowed for the psychiatrist to address pertinent diagnostic and medication information. If diagnostics are not appropriately decided in a clinically justifiable manner, other aspects of psychiatric care will be less likely to be provided correctly, such as successful reduction of polypharmacy regimens. During the last review, in order to improve documentation about evaluating and diagnosing individuals in a clinically justifiable manner, a policy was presented called "Psychiatric Care & Services." It 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 during the clinic process. • It would be helpful for the psychiatrist to have assistance during the clinic process to allow the psychiatrist to review the records, interact with the IDT, and to conduct the mental status examination of the individual while another staff member does the entering/typing of this information. • Of course, there would be some prep time ahead of the clinic that would be necessary to accomplish this task. The case formulations for quarterly examinations were either nonexistent or 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. Although there was not a specific section on the QPMR to document a case formulation, the psychiatrists had a space to include the justification for the diagnosis that summarized partial wording (i.e., specific symptoms) of a case formulation. <u>Monitoring Team's Compliance Rating</u> The facility made progress with regard to the implementation of the electronic quarterly	

#	Provision	Assessment of Status	Compliance
		psychiatric assessments. The monitoring team's assessment is that evaluation, diagnosis, and justification for treatment with medication remained insufficient, therefore, this rating remains as noncompliance.	
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> For the majority of individuals prescribed medication, there was a diagnosis cited in the record. The consent for the medication, however, frequently did not list the accurate diagnosis for the purpose of the medication. Additionally, there were other occurrences where the diagnosis provided by psychiatry differed from that included in other documents (i.e., PBSP, neurology consultation). An example of an individual prescribed medication without a diagnosis was found during this review. This was discovered during the clinic between the neurologist and the psychiatrist for Individual #934. The neurologist showed the monitoring team that the medication record for this individual (who had a complex neuropsychiatric condition) did not list the indication for Topamax. 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. While the records reviewed for individuals prescribed medication mostly 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 cohesive differential diagnoses and case formulation and to jointly determine clinical indicators. In this process, the IDT should 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 be documented in the individual's record in a timely manner. The PBSP documents included information regarding the psychopharmacological regimen, medication side effects, and medication changes. This information, however, was not dependably developed in consultation 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. On a positive note, since the last review, the consent for newly prescribed psychotropic medication was now the responsibility of the prescribing psychiatrist or prescribing physician. Consent is reviewed in J14.	Noncompliance

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<u>Emergency use of psychotropic medications</u>:
The monitoring team was provided a numbered spreadsheet of individuals requiring utilization of chemical restraints in the last six months. There were five incidents from 5/12/12 to 8/4/12. Progress was noted because there was a decrease of eight administrations of chemical restraints from the previous review. Further, previously, the chemical restraint upon each administration was a combination of three different medications administered via intramuscular injection (Haldol 5 mg, Ativan 2 mg, Benadryl 25 mg). The determination of chemical restraint medication now appeared to be made on a more individualized basis. The administration of chemical restraints for this visit is summarized below.

<table>
<tr><td>Individual #</td><td>Date of Chemical Restraint</td><td>Medication Administered and Route</td></tr>
<tr><td>Individual #9</td><td>5/12/12</td><td>Ativan 2 mg and Haldol 5 mg Intramuscularly</td></tr>
<tr><td>Individual #506</td><td>5/23/12</td><td>Ativan 2 mg, Haldol 10 mg, and Benadryl 50 mg Intramuscularly</td></tr>
<tr><td>Individual #589</td><td>6/9/12</td><td>Haldol 5 mg and Benadryl 25 mg Intramuscularly</td></tr>
<tr><td>Individual #373</td><td>7/21/12</td><td>Ativan 1 mg Intramuscularly</td></tr>
<tr><td>Individual #589</td><td>8/4/12</td><td>Haldol 5 mg and Benadryl 25 mg Intramuscularly</td></tr>
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A review of the record of Individual #589 revealed the following:
• Individual #589 received a restrictive intervention of administration of two separate chemical restraints, but the ISP addendums held shortly after the injection, dated 8/6/12 and 6/11/12, 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 (i.e., amendment to the interdisciplinary treatment plan) with goal of reduction of the use of emergency medication.
• It should be noted that Individual #589 was also administered two chemical restraints (2/7/12, 2/11/12) during the last review period.

<u>Monitoring Team's Compliance Rating</u>
The facility was in noncompliance due to inconsistent integration between psychiatry and psychology regarding treatment planning, non-pharmacological interventions, and behavioral support planning. The facility had done a nice job with regard to the reduction and minimal utilization of chemical restraints, but continued to struggle with over prescription of psychotropic medication and polypharmacy (outlined in J13).
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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 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.	Extent of Pretreatment Sedation The monitoring team was informed there had been no administration of any pretreatment sedation at MSSLC for either medical or dental clinic since 3/1/12. Note, however, that this calculation did not include pretreatment sedation that was given for dental or medical purposes at any offsite facilities. This number for dental and medical procedures should be incorporated into the MSSLC data. The monitoring team requested 10 examples of documentation of psychiatry consultation regarding pretreatment sedation for dental or medical clinic. The monitoring team was provided no case illustrations because there was no pretreatment sedation given at the facility since 3/1/12. Interdisciplinary Coordination The monitoring team was informed that there were no new policies for section J since the last review. The facility must present new and updated policies and procedures to the monitoring team that are relevant to the 15 provision items. For example, during the visit and review of section J, the psychiatry department did not update the monitoring team about the desensitization committee policy dated 8/1/12 or the pretreatment sedation and post-sedation monitoring policy dated 4/1/12, both vital to this provision. The monitoring team attended the desensitization committee. While there was progress in communication among disciplines (i.e., dental, nursing, psychology), the committee was not able to present to the monitoring team the list of the individuals who received pretreatment sedation, (offsite or onsite), and did not know the results of the nursing post-sedation monitoring. The committee mostly focused on which individuals were having difficulty with dental appointments and determined those who may benefit from a desensitization plan. Discussion during the desensitization committee should also review the pretreatment sedation ordered offsite as well as at MSSLC and the results of post-sedation monitoring. The facility should not misunderstand the purpose of this provision, that is, staff should not resort to individuals never receiving administration of medication, when warranted, for necessary dental and/or medical treatment. The facility must be knowledgeable about any medication the individual receives and conduct interdisciplinary coordination to 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 per the psychiatrist in order to avoid over-medication. • Additionally, the status of the individual who received medication offsite and the results of monitoring and potential drug-drug interactions with regular medications mandate review. • Regarding offsite medical procedures, most individuals would likely return to the facility the same day and receive the same routine medication regimen inclusive of	Noncompliance

#	Provision	Assessment of Status	Compliance
		possible psychotropic medication, polypharmacy, and multiple medications to target a neuropsychiatric condition. • It is not acceptable to excuse the facility from all pretreatment sedation Settlement Agreement monitoring just because medication was administered offsite. 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, but not at the expense of sending individuals to community providers for sedating medication. Furthermore, formal desensitization programs may not be necessary for all individuals (though certainly will be necessary for some individuals). <u>Monitoring After Pretreatment Sedation</u> There was development of a nursing policy and procedure formalized 4/1/12 regarding pretreatment and post-sedation monitoring. The policy 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 used in combination with other medications for medical and/or psychiatric conditions). The clinical pharmacist would also be instrumental in providing the medication interactions and potential interactions of pretreatment sedation agents with concurrently prescribed medication. • There was no case example provided for this section because no one received pretreatment sedation at MSSLC since last review. • The facility needs to be aware about the details of offsite pretreatment sedation and the potential effects of the medication administered to the individual even if administered at another facility. • The facility must monitor individuals who have received pretreatment sedation elsewhere and then returned to MSSLC on the same date because of the possible synergistic activity (between these agents and the routine medications prescribed). • The main purpose of monitoring was for staff to be knowledgeable about the individual's medical status (e.g., experienced harmful effects of the pretreatment sedation such as side effects and/or drug-drug interactions). <u>Desensitization Protocols and Other Strategies</u> A list of all individuals with medical/dental desensitization plans and date of implementation were requested. There was one medical desensitization plan developed for Individual #196 in addition to a dental desensitization plan, both implemented on 7/31/12. Additionally since last visit, there was the development of dental desensitization plans for Individual #456 (implemented 5/14/12) and Individual #484 (implemented 7/24/12).	

#	Provision	Assessment of Status	Compliance
		Consent was not necessary regarding pretreatment sedation because no one received pretreatment sedation at MSSLC. Effective 2/1/12, there was a memo stating "all non-emergent cases of pretreatment sedation will be submitted to MRC for approval." The IDTs were beginning to address whether or not the individual required a desensitization plan in the ISP Addendum. 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. <u>Monitoring Team's Compliance Rating</u> Calculation of pretreatment sedation that was given for dental or medical purposes at any offsite facilities must be incorporated into the MSSLC data set in addition to the monitoring results after pretreatment sedation (even when administered offsite). Monitoring would occur upon return of the individual to MSSLC. This item will remain in noncompliance because further effort must be made with 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 9/24/12 (a total of 259 individuals). Of these, 63 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. The other full-time equivalent locum tenens psychiatrist worked with the lead psychiatrist since the last review. The facility self-assessment for J5 noted the following: "this provision is in noncompliance due to overlapping time commitments for Self-Assessment Tool completions, clinical duties, Settlement Agreement Activities, trainings, and other document production activities." The board certified forensic, adult, and child psychiatrist had, but no longer, provided phone consultation every week to the general psychiatrists (see J1). The psychiatric clinic schedule listed each psychiatrist as working 40 hours each week. The psychiatric staff rotated on call a week at a time. Each psychiatrist attended IDT, ISPA, and other various meetings as needed. The facility noted that four FTE psychiatrists would be required in order to allow the psychiatrist to address the following duties: • provide care for an average of 60-70 individuals assigned to their caseload; • completion of Appendix B comprehensive assessments;	Noncompliance

#	Provision	Assessment of Status	Compliance
		• conducting quarterly reviews; • attendance at meetings (e.g., polypharmacy committee, IDT meetings, behavior therapy committee, physician's meetings, behavior support planning); • participating in other clinical activity, such as collaboration with primary care, nursing, neurology, other medical consultants, pharmacy, psychology; • provision of emergency psychiatric consultation; • more frequent monitoring for individuals whose medication dosages or regimen had recently been adjusted. <u>Administrative Support</u> There were two designated full-time psychiatric assistants, Ms. Virginia Jackson and Ms. Bobbie Hall. They provided 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. <u>Determination of Required FTEs</u> Overall, it appeared that MSSLC had done an adequate job in assessing the amount of psychiatric FTEs required. The number of hours calculated for the provisions of psychiatric services were developed to take into account not only clinical responsibility, but also documentation of delivered care such as quarterly reviews and Appendix B comprehensive evaluations, and required meeting time (e.g., physician's meetings, behavior support planning, emergency ISPA attendance, discussions with nursing staff, call responsibility, and participation in polypharmacy meetings). <u>Monitoring Team's Compliance Rating</u> Per the facility self-assessment, MSSLC was approved 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 equivalent psychiatrists at MSSLC at the time of the visit. MSSLC had 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	<u>Appendix B Evaluations Completed</u> MSSLC provided a five-page document, unnumbered, with the names of individuals who received an Appendix B assessment dating back to 2010. According to the monitoring team's calculation, 225 individuals had psychiatric evaluations performed according to Appendix B, which indicated that an additional 34 individuals still required a comprehensive psychiatric assessment. Thus 87% of the evaluations, as described in Appendix B, reportedly, had been completed. Given the remaining number of comprehensive psychiatric assessments, this provision will remain in noncompliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
	current, generally accepted professional standards of care, as described in Appendix B.	At the time of the last monitoring visit, 181 psychiatric assessments had been completed for the individuals enrolled in psychiatric clinic. Thus, 44 comprehensive psychiatric assessments had been completed since then. The data indicated an average of 7.33 assessments were completed per month. Although progress was occurring, at this rate, it would take 4.5 more months to complete all of them, without any new admissions to the facility. Appendix B style evaluations were reviewed for the following 10 individuals: Individual #520, Individual #754, Individual #700, Individual #253, Individual #434, Individual #426, Individual #170, Individual #745, Individual #614, and Individual #499. The monitoring team received an Appendix B evaluation for Individual #754, who was a new admission to MSSLC, but was not prescribed psychotropic medication, and did not have an Axis I diagnosis. Appendix B evaluations should be reserved for identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication. The facility psychiatry department should utilize its resources more efficiently and implement the Reiss Screen for Maladaptive Behavior to screen such individuals upon admission (see section J7). The assessments generally followed the Appendix B outline and reflected adequate documentation. Below are comments from the monitoring team. • Vital signs were now included in the physical exam section. The monitoring team encourages documentation of orthostatic blood pressure and pulse (i.e., lying/standing BP and lying/standing pulse) for individuals who receive psychotropic medication because these agents potentially result in a change in orthostatic vital signs. • 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 who are 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) should be included in the report. If not available, there should be a recommendation to obtain it, if clinically indicated. • The case formulation should identify detailed reasons for the justification of the chosen diagnostics in an outline in line with the DSM-IV-TR. The biopsychosocial approach and language similar to the DSM-IV-TR would guide the reader about why other, or additional, diagnoses were considered, such as an assigned rule out condition. • Treatment recommendations also need to outline intention of each medication and	

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		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. <u>Monitoring Team's Compliance Rating</u> The facility self-rated noncompliance due to data being "insufficient to reflect substantial compliance." Given the remaining number of comprehensive psychiatric assessments this provision will remain in noncompliance. The monitoring team encouraged the facility to use this report to mirror and report similar findings. To date, the monitoring team calculated this information, but the facility must do the same to self-rate, and then present the findings to the monitoring team.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	<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. The facility had 28 new admissions since last visit. 100% of these individuals received a Reiss Screen within 30 days of their admission date. The facility reported that all new admissions also received a comprehensive psychiatric evaluation, so there were no separate referrals for psychiatric evaluation following the Reiss screen. The self-assessment noted "based on findings of this self-assessment data and due to all activities to assess compliance have not been initiated, data is insufficient to reflect substantial compliance. This provision is not in substantial compliance." <u>Reiss Screen for Change in Status</u> There was no process for determining when a change in status should result in a Reiss screen being implemented. The facility should become familiar with other state centers in regards to addressing time frames for seeking a psychiatric evaluation for those identified with the Reiss screen. 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>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> The monitoring team received two different documents. • First, MSSLC sent a list of new facility admissions for the previous six months, whether a Reiss screen was completed, and results of the screen indicating whether or not an individual had a need for psychiatric services. • Second, MSSLC sent a spreadsheet of all individuals who had had a Reiss screen	Noncompliance

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		completed in the previous 12 months, including the individual's name, date of admission, date of completion of the Reiss screen, the results of the screen indicating whether or not an individual had a need for psychiatric services, and the date of the comprehensive psychiatric evaluation per Appendix B. There were discrepancies between these two documents. For example, Individual #366 was deemed to be in need of psychiatric services in one document, but not in the other. Also perplexing was the fact that psychiatric evaluation of Individual #366 was reportedly completed before the admission date to MSSLC. This was also seen with other cases (e.g., Individual #384, Individual #9). Upon review of the psychiatry roster, all three of the individuals were enrolled in the psychiatry clinic. This section 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. Appendix B-style assessment was addressed in Section J6. <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. The monitoring team encouraged the facility to use this report to guide its activities regarding section J7.	
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 MSSLC 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> In order to address this, the facility initiated a psychiatry/psychology integration forum since the last visit. Meetings that occurred between psychiatry and psychology were dated 8/6/12, 8/17/12, 8/24/12, 8/31/12, 9/7/12, 9/14/12, 9/21/12, and 9/26/12. The monitoring team attended the psychiatry/psychology integration meeting on 9/26/12. There were multiple positive outcomes from these meetings. The staff from both departments discussed ways of addressing combined assessment and case formulation. One of the goals was the development of a "conjoint biopsychosocial assessment between psychiatry and psychology." Subsequent meetings addressed the development of a form (integrated psychosocial diagnostic formulation – the IPSD). This included a	Noncompliance

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		summary/diagnostic formulation section and diagnostic impression within these assessments. Other meetings deliberated the time period for the psychiatry department to take over the role of implementation of consents for psychotropic medication, rather than the psychology department (discussed in J14). The monitoring team also observed several psychiatric clinics. IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (i.e., 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 deemed necessary for monitoring of the current psychiatric diagnosis. This was the result of the psychiatrist not focusing on the reason the medication was prescribed. Instead, the IDT inquired predominantly about behavioral presentation, such as aggression towards others and SIB. 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. There were a number of discrepancies found in the documentation in multiple areas. Accuracy regarding an individual's level of impairment on Axis I and II is imperative,	

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		because effective treatment relies upon accurate diagnoses. For example, Individual #68's diagnoses were found to be inconsistent across documents. The psychiatrist's Quarterly Psychiatric Medication Review (9/27/12) noted Axis I diagnoses to be Major Depressive Disorder and Cannabis Abuse (in institutional remission), while the ISP (8/1/12) reported the Axis I diagnoses to be Conduct Disorder and Cannabis Abuse. It is also worth noting that this individual's symptoms of Depressive Disorder were in remission on 6/25/12. Furthermore, during the psychiatry clinic visit observed by the monitoring team, this individual denied any depressive symptomatology. However, as highlighted in the summary below, some disciplines, inclusive of psychiatry, continued to cite this individual as having Major Depressive Disorder. The psychiatrist informed the IDT during the clinic for Individual #68 that there were no clear indications for Seroquel at the time of the consult, but the IDT wanted the psychiatrist to continue the psychotropic regimen as prescribed. The psychiatrist contemplated that the individual may have an Impulse Control Disorder, but rather than following the proper protocol to establish a rule-out of a potential change in diagnoses and an establishment of appropriate indications for the medication, the psychiatrist verbally stated, "that's a lot of paperwork, leave it like it is." Furthermore, the psychiatrist reported in the QPMR (9/27/12), "today I cannot diagnose any axis I diagnosis. I am most concerned about his use of drugs when he returns to the community and continuing the Seroquel without a good diagnosis." • The requirements of a diagnostic assessment as cited in the settlement agreement (Appendix B) noted that, "all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review" (Appendix B, XII.A). A detailed summary of these discrepancies for Individual #68 are below: Document / Axis I Diagnoses Psychological Evaluation (4/23/12) / Cannabis Abuse; Conduct Disorder QPMR: Psychiatrist (6/25/12) / Depressive Disorder (in remission) Physician: Annual Medical Review (7/10/12) / Major Depressive Disorder Individual Support Plan (8/1/12) / Cannabis Abuse; Conduct Disorder Comprehensive Nursing Assessment (8/1/12) / Major Depressive Disorder; Cannabis Abuse PBSP (8/15/12) / Major Depressive Disorder, NOS QPMR: Psychiatrist (9/27/12) / Major Depressive Disorder; Cannabis Abuse (in institutional remission) Similar discrepancies were also found among Individual #68's Axis II diagnoses. As the individual had a diagnosis of Mild Mental Retardation upon the initial psychiatric evaluation, subsequent documentation did not match his level of intellectual disability to reflect the results of the psychological evaluation on 4/23/12. This should lead to clinical assessment for an individual who had a noted deterioration in level of cognitive functioning.	

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		These documents are outlined below: Similar discrepancies between diagnoses across reviewed documentation were discovered for other individuals (e.g., Individual #133, Individual #550, Individual #589). <u>Combined Assessment and Case Formulation</u> The case formulation should consist of the following sequential tasks, undertaken to channel distinct disciplinary assessments into the creation of an integrated treatment plan. These steps should include review and integration of information from the disciplinary assessments, identification of factors (i.e., biological, psychological, social, and spiritual), creation of clinically-based predictions about the individual's needs, and design of integrated treatment, habilitation, and enrichment interventions. The lack of consistent identification of updated diagnostics negatively resulted in the inadequate selection of an evidence based psychotropic medication. This poses a serious problem when implementing a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. The treatment plan for the psychotropic medication regimen should identify a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis, which will be addressed in J13. <u>Coordination of behavioral and pharmacologic treatments</u> There was cause for concern because the team had not integrated 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 as outlined in this section. 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.	

Document	Date	Axis II Diagnosis
Initial Psychiatric Evaluation	11/09	Mild Mental Retardation
Psychological Evaluation	4/23/12	Moderate Mental Retardation
Nursing Report for QPMR Worksheet	6/25/12	Moderate Mental Retardation
Physician's Annual Medical Review	7/10/12	Mild Mental Retardation
Active Problem List	7/10/12	Mild Mental Retardation
Individual Support Plan	8/1/12	Moderate Mental Retardation
Positive Behavior Support Plan	8/15/12	Moderate Mental Retardation
Psychiatrist Master Bill	9/27/12	Moderate Mental Retardation

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		However, it was difficult for psychology and psychiatry to establish a steady working relationship because of the staff turnover. For example, turnover resulted in different psychiatrists being responsible for the psychiatric care of an individual, and as a result, diagnostics and treatment regimens changed. When this occurs without the integration and support of the 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 applicable to the assigned diagnosis. 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 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	<u>Psychiatry Participation in PBSP</u> During the previous review in March 2012, the monitoring team noted that 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. Since the last visit, the facility reported increased participation by psychiatrists in the 3rd Quarter ISP preparation meetings and annual ISP meetings, including participation with the IDT in creation of the PBSP. Additionally, a list of all meetings and rounds typically attended by the psychiatrist was provided to the monitoring team. These meetings included ISP meetings, ISPA meetings, BTC meetings, physicians' meetings, medical review committee meetings, and polypharmacy review committee meetings. According to the self-assessment, insufficient evidence was available to reflect substantial compliance, thus, the facility was in noncompliance. During the prior visit, 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 individuals' care. The BTC process, however, remained the same. The monitoring team observed the BTC committee. It was apparent that psychiatry had not assisted the psychology department in preparation of the document. In BTC, the prescribing psychiatrists do not always review their own case, therefore, the psychiatrist at the BTC may not be familiar with the individual being reviewed. Further, there had been 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	Noncompliance

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	psychotropic medication to the degree possible.	development of the PBSP as specified in the wording of this provision item, and that the required elements are included in the document. The following example illustrated psychiatry participation in the development of the PBSP, however, it was insufficient in outlining the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. • The medication plan dated 2/2/12 for Individual #639 noted that Lexapro was prescribed in order to reduce inappropriate sexual behavior secondary to his diagnosis of impulse control disorder, not otherwise specified. • The consent form dated 8/30/12 did not cite this as the reason that the medication was prescribed. The consent form outlined that Lexapro was prescribed for intermittent explosive disorder, including property destruction and aggression toward others. The benefit of the Lexapro on the consent form was specifically a reduction in symptoms of intermittent explosive disorder. • The PBSP dated 9/30/12, although signed by the psychiatrist, did not outline the purpose of the utilization of the SSRI medication (i.e., Lexapro reducing inappropriate sexual behavior) and did not 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. Medication to reduce an individual's sexual drive was a highly restrictive intervention, the consent process was improperly obtained, and less restrictive alternatives were not addressed in the PBSP to target the inappropriate sexual behavior. This practice pattern deviated from the generally accepted professional standard of care. <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 meeting was burdensome due to numerous plans that required approval and, therefore, not the best	

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		setting for in depth discussion with the psychiatrist. The monitoring team provided summary in the last report encouraging the psychiatrist to 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. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> During the psychiatric clinics observed, the IDT predominantly requested the psychiatrist to continue the psychotropic medication regimen. There was lack of discussion in regards to non-pharmacological interventions. Last monitoring visit, 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. • On a positive note, the monitoring team received a document dated 7/12 that summarized overall ISP attendance tracking of team members. o However, this document showed that psychiatrists only attended a total of 15 out of 36 (42%) meetings, and did not specify a range of dates for these meetings (e.g., was this data only obtained since last review). o Some of the documentation for the member's signature lines were typed which made it easier for determination if a psychiatrist was in attendance. • Also, the monitoring team received a one-page list with dates from 3/13/12 to 8/2/12 noting that the psychiatrists attended 12 ISP preparation meetings in this period. o The total number of ISP preparation meetings held in this review period regarding individuals who received psychotropic medication was not provided. o MSSLC should collect data about which specific meetings psychiatric staff attended, preferably within the numbered spreadsheet of individuals prescribed psychotropic/psychiatric medication for each individual. o Similar to the ISP attendance tracking of team members, it would be beneficial for the facility to summarize attendance tracking of the psychiatrists' participation for the other meetings as well. <u>Monitoring Team's Compliance Rating</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. Furthermore,	

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		when psychiatry participated, the elements of this section were not consistently implemented. 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 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.	<u>Policy and Procedure</u> 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" 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> There was the development of the electronic QPMR form since the last visit. This form provided a section for the psychiatrist to list risks, benefits, potential side effects of a medication regimen, and alternative treatments. For example, for Individual #30, the psychiatrist outlined the risks associated with the various medications prescribed. Potential side effects were not outlined specific to each medication prescribed. The psychiatrist did not list the specific benefits of each medication within the section of the document labeled "Benefits," however, symptoms were appropriately addressed in alignment with the medication prescribed elsewhere (e.g., Risperdal – psychotic symptoms). Alternatives listed "BSP," although this individual was noted to have a psychotic condition that would not best be addressed solely via the BSP. The section labeled "Justification" was left blank for this individual, despite drug interactions checked "Yes" on the form, and specifics were not outlined to document the risk/benefit analysis. 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.	Noncompliance

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		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 standards 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 in 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 stressed the importance of the psychiatrist and the IDT reviewing the content of this provision and, further, that it was not adequate to have medications outlined with generic statements in the PBSP. There was similar language used for the medication plan no matter what class of medication was prescribed, therefore, the plans were not individualized. 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 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, a reasonable estimate of the probability of success, and the establishment of reasonable alternative strategies. During the clinic process, the team should type the information using the computer in the clinic with a projector/screen in order to review this material together (addressed in J2). It was apparent that the psychiatrist struggled with completing multiple tasks without assistance including the typing of relevant information while reviewing the record and attempting to interview the individual, all at once.	

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		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). 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. <u>Human Rights Committee Activities</u> 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). <u>Monitoring Team's Compliance Rating</u> Although there were improvements noted with regard to psychiatric participation via the development of the QPMR form, challenges remained. The records did not reveal documentation by the psychiatric physician of a specific risk/benefit analysis for the individual prescribed psychotropic medication as required by this provision item. Given these deficiencies, this provision will remain in noncompliance.	
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.	<u>Facility-Level Review System</u> The lead psychiatrist reported that the polypharmacy meetings were placing emphasis on potential drug-drug interactions and ADRs. The psychiatry department must be knowledgeable about all new policies and procedures developed and revised affecting the collaboration and integration of services for the delivery of psychiatric services (e.g., adverse drug reactions approved 8/16/12). The psychiatry department reported that there were no new policies for provision J, but should consider the Quarterly Drug Regimen Review policy and procedure (Medical #29 approved 8/2/12) to be a vital component to address this section of the Settlement Agreement. For example the definition of polypharmacy "the prescription of two or more psychotropic medications from the same general class…to the same individual, and the prescription of three or more psychotropic medications, regardless of the class, to the same individual," was cited in this policy. 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. The facility psychiatrists were defensive about the necessity of the polypharmacy regimen for the individuals under their care. For numerous site visits, there has been a resistance, facility-wide, to not reduce psychotropic medication even if there was not a suitable indication for the prescription of the polypharmacy regimen.	Noncompliance

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		Furthermore, there was a need for the neurologist and psychiatrist to review the designated individuals with neuropsychiatric condition to determine if the AED and/or benzodiazepines was prescribed solely for the treatment of the seizure disorder and/or for the psychiatric disorder (addressed in J15). The monitoring team attended the polypharmacy meeting. The pharmacy director corrected the data collection due to request of the monitoring team during last visit. The pharmacy director was receptive to feedback by the monitoring team and addressed the requests as follows: • The pharmacy department provided the monitoring team with the number of individuals classified as receiving this type of regimen in addition to the total number of individuals prescribed psychotropic medication at MSSLC. This was appropriate and an improvement because 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. o 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. 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 justification for polypharmacy derived during psychiatry clinic. This element was missing, as the existing facility level review process was ill prepared regarding the individuals' case specifics, attempted to run a psychiatry clinic during this time period (i.e., clarifying diagnostics, not knowledgeable about indication for the AED medication), as opposed to succinctly presenting findings to the committee. <u>Review of Polypharmacy Data</u> For future onsite reviews by the monitoring team, it would be helpful for the polypharmacy review to always take place at the beginning of the week (as was done during this review) so that the monitoring team can provide feedback throughout the remainder of the week. Also, during this review, the monitoring team gave feedback to the polypharmacy committee regarding the case discussions presented by the psychiatrist. The polypharmacy summary was presented in the Pharmacy and Therapeutics Committee during this onsite review. It noted the results of the August 2012 data as follows:	

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		• There were 103 individuals prescribed polypharmacy of the 266 receiving a psychotropic regimen. Thus, there were 39% "polypharmacy cases" at MSSLC. • Reasons (provided by pharmacy) for change in polypharmacy numbers included: o there were nine new admissions in July with one individual ordered polypharmacy (e.g., Individual #639) o three additional individuals "now have polypharmacy" (e.g., Individual #529, Individual #290, and Individual #401) o three individuals no longer received polypharmacy (e.g., Individual #390, Individual #422, and Individual #411) o two individuals were discharged (e.g., Individual #482, and Individual #337). As noted in the previous monitoring report, information for this section did not include the total number of individuals receiving psychotropic medication when calculating the data. The data were similar this review period because there was one individual who received as many as six psychotropic medications, seven individuals were prescribed five medications, 36 individuals received four medications, 56 were ordered three medications, and 33 individuals received intra-class within polypharmacy. 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 9/10/12 provided the names of 31 individuals. In summary, the facility made progress with capturing 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. <u>Review of Polypharmacy Justifications</u> The review of the polypharmacy justifications provided to the monitoring team (i.e., per document request, via polypharmacy committee, information provided upon inquiry by the monitoring team in psychiatric clinics) highlighted attempts by the IDT to address the topic of justification of the utilization psychotropic medications, specifically polypharmacy. However, at the polypharmacy committee, attendees had the burdensome task of listening to some case presentations that were not well known by the psychiatrist, while others recited 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.	

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		For example, the committee had a lengthy discussion due to the difference of opinions about the indication of the medication for Individual #177. The psychiatrist informed the monitoring team that this individual had a history of a seizure disorder and the current indication for the AED was only Axis I. Conversely, the drug regimen review profile for Individual #177 cited the AED for both Axis I disorder and seizure disorder. The lack of consistency in information was further noted in the psychoactive medication polypharmacy roster because Individual #177 was noted to receive the AED for the target symptoms associated with Axis I without any mention of a seizure disorder. Fortunately, the other medical staff, William Thomas, was present and informed the psychiatrist about the neurologist indicating that Individual #177 would always require an AED for epilepsy due to his medical condition. The psychiatry department and the pharmacy department should have the same documentation about the indication of all medications prescribed for each individual enrolled in the psychiatry clinic. 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 established indications that must be appropriately presented to the Human Rights Committee, and for the determination of 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. 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. <u>Monitoring Team's Compliance Rating</u> The pharmacy department made progress in setting up an established system level of review of polypharmacy, but the psychiatrists (with the IDT) now need to focus on review of the justification of the prescription of the polypharmacy regimen. This should occur in the psychiatric clinic with documentation spelled out in the new QPMR electronic form. The facility continued to struggle with the elimination of medications that were not clinically justified. Thus, this provision was rated in noncompliance.	

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J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS) The facility provided information regarding scores and dates of completion of evaluations dated February 2012 through August 2012. DISCUS monitoring per the facility guidelines was to occur upon admission, "baseline," every 3 months, one month "following discontinuance," two months "following discontinuance," three months "following discontinuance," and six months "following discontinuance." Review of this information revealed delay in completion of the DISCUS given that the goal was administration every three months. For example, Individual #595, Individual #451, and Individual #33, each had one administration of the DISCUS in this review period. There was no follow-up DISCUS entry for any of these individuals and no documentation indicating if the individuals were no longer receiving services at MSSLC. MOSES monitoring per the facility guidelines was to occur upon admission, "baseline," with drug initiation, and every three months. Review of this information revealed delay in completion of the MOSES given the specified goals. Similar findings were noted for the above referenced individuals, however, there was not a score given for the MOSES for Individual #33, who apparently received psychotropic medications, due to the administration of the DISCUS. Psychiatry must utilize this information and work together with nursing to guarantee this process was 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. The facility should provide a summary of the findings of the content for this section to the monitoring team, such as the number and percentage of individuals that received the DISCUS and the MOSES as outlined in the facility policy addressing this section. The facility should provide an overview of the reasons for not obtaining a follow-up, such as a notation if the individual was discharged from the facility or was no longer receiving psychotropic medication, if this was the case. This is one example of how the facility can self-monitor the requirements of this provision item. Training Summary of the program content for the training listed MOSES, DISCUS assessments, monitoring of weight issues, and numerous other topics. Due to the staff displaying a wide range of responses about the definition of an adverse drug reaction (e.g., an unexpected, unintended, undesired, or dangerous effect that a drug may have, that occurs at doses used in humans for prophylaxis), it was recommended that ADR training occur in sequence with the MOSES/DISCUS training. This would aid staff to associate that the purpose of the monitoring/detecting with the reporting requirement (i.e., ADR) and responding to the findings. For facility nursing staff, the training that occurred 4/12/12 to 4/24/12 listed the	Noncompliance

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		signatures of two RNs. The training that took place from 6/13/12 to 6/25/12 listed the signatures of two RNs. The training for the period 7/23/12 to 8/1/12 had 12 staff in attendance, including LVNs and RNs. Therefore a total of 16 nursing staff participated in the training. The facility was making efforts, as such, to address this section. <u>Results of the Side Effect Rating Scales</u> Detecting, reporting, and responding to side effects of psychotropic medication, secondary to interpretation of the scales, is a complex task. The evaluator must take into consideration the individual's medical status and determine what conditions may resemble side effects of the medication. For example, individuals who are edentulous may present with oral buccal movements, but do not necessarily have tardive dyskinesia. Once side effects were detected, reporting was to occur and response taken based on the individual's status. During committee meetings (i.e., P&T committee) with the psychiatrists and medical staff, the monitoring team witnessed hesitancy in the process of filing an ADR during discussion of hypothetical case examples of individuals who may have experienced an adverse reaction to the medication. The IDT did not understand the importance of actually reporting, and they feared medical-legal problems, if the ADR was reported and the agent was still prescribed. This resulted in the next discussion about the importance of the risk/benefit analysis and justification of continuation of medications, particularly in such situations. During last review, 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. This review period, the list only noted the names of five individuals diagnosed with TD: Individual #502, Individual #276, Individual #462, Individual #562, and Individual #304. The report of only five individuals having a diagnosis of TD resulted in the monitoring team's concern about the 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. • 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 DISCUS score due to involuntary movements. The individual may also experience restlessness and agitation, therefore, the presentation of symptoms may be confused with an exacerbation of an Axis I disorder. Therefore, all diagnoses, inclusive of TD, must be routinely reviewed and documented.	

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		Monitoring Team's Compliance Rating The facility should provide a summary of the findings of the content for this section to the monitoring team, inclusive of percentage of individuals who received the DISCUS and the MOSES in a timely fashion. Additionally, given the need for the demonstration of the consistent identification of individuals (i.e., obtaining pertinent medical history 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 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.	Policy and Procedure 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 reflected the language in this provision item. Numerous changes had taken place in the psychiatric services at MSSLC. The psychiatry staff did not place emphasis on revision of the policy and procedures. Upon inquiry about the details of the statewide and facility policies for psychiatric services, it seemed clear that the staff were not knowledgeable about which policy was the most updated document (e.g., psychiatry department staff had to check with another department to clarify which policy and procedure to reference). Frequency of Consultation with the Psychiatrist Per interviews with the two full time psychiatric assistants who coordinated the psychiatrists' schedules and the clinic management, individuals were to be seen in clinic at a minimum of once per quarter for their quarterly medication review. There was a discrepancy noted in 74 out of 259 cases (29%) where individuals were not evaluated by a psychiatrist within a 90-day period ranging from 3/8/12 to 9/8/12. These data should be summarized as outlined per the facility as part of the necessary components of their self-assessment. The facility had gathered the necessary information in order to calculate the percentage, but did not utilize this information to self-monitor and manage. • There was insufficient documentation for providing rationale as to why some cases were assessed less often than quarterly, such as perhaps due to lack of consistency of psychiatric staffing during a certain time period. • If the data gathered indicated that the individuals were not examined in the 90-day period, this should have triggered a referral for the IDT, including the psychiatrist, to meet with the individual in order to ensure that the treatment plan was meeting the needs of the individual as required by the Settlement Agreement.	Noncompliance

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		Conversely, it was noted that for 120 out of 259 cases (46%), follow-up consultations were conducted frequently throughout the period from 3/8/12 to 9/8/12. In fact, individuals were evaluated up to six times during this time period by the psychiatrist. This was notable of advancement being made in this section. <u>Treatment Plan for the Psychotropic Medication</u> Since last visit there was the implementation of an electronic QPMR for the psychiatrist to use as documentation of the psychiatric consultation. The new format had sections that allowed for justification for the previous diagnosis and current diagnosis, timeline for medication effects, and psychiatric symptoms monitored to assess efficacy. 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. While there was definite improvement in the documentation in the electronic QPMR, there remained inconsistent justification of the rationale for the psychiatrist choosing the medication (i.e., the current diagnosis or the behavioral/pharmacological treatment hypothesis). Other required elements (the expected timeline for the therapeutic effects of the medication to occur, the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur) were not consistently outlined in the records. The monitoring team was provided 10 QPMRs in the new electronic format. Individual #106 was a good example of the headway made in psychiatric services since last visit. The psychiatrist noted that the individual was depressed and provided justification for a change in diagnosis to mood disorder, NOS (e.g., mood swings, depression, and impulsivity). A recommendation was made to increase the AED agent with a timeline for medication effects listed as two to four weeks. Monitoring parameters included AED level and other labs to be obtained, including vital signs and screening scales. Other therapeutic measures, such as individual therapy was recommended for this individual with mild intellectual disability with a return appointment scheduled in four weeks. Conversely, for Individual #434, there were blank lines for the following: risks, benefits, potential side effects, alternatives, timeline for medication effects, psychiatric symptoms monitored to assess efficacy, and monitoring parameters. Some psychiatrists stated that the form was burdensome and, perhaps as a result, only filled out partial sections. Even so, it was appropriate for Individual #434 to receive an agent, such as Methylphenidate ER for the established diagnosis of ADHD. For every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan addressed the components outlined in this section. The ISP could summarize the content of the QPMR form completed by the	

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		psychiatry department with input from the IDT. This delivery of care would meet generally accepted professional standards of care if thoroughly completed and relevant resulting in the essential treatment for the individual. The psychiatry department must utilize the findings written in the QDRRs to enhance clinical care of the individual, and provide documentation in the QPMR of doing so, rather than just check off the box saying that the QDRR was reviewed. The QDRRs were available as a tool developed for systematic review for those individuals receiving medication, such as psychotropics (section N). The sharing of information between disciplines must be a basic, standard, accepted process, especially due to the numerous staff changes that occurred in the psychiatry department. <u>Psychiatry Participation in ISP Meetings</u> At the time of the onsite monitoring review, there was some psychiatry participation in the ISP process (addressed in J9). The facility had one full time psychiatrist and relied on contracted psychiatric providers. The lack of a full complement of psychiatrists did not allow for their attendance for the majority of the ISP meetings. In an effort to utilize staff resources most effectively, the facility could consider incorporating some components of the IDT meetings into the psychiatry clinic process. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the IDT in psychiatry clinic may allow for improvements in overall team cohesion, information sharing, collaborative case conceptualization and management. <u>Psychiatry Clinic</u> During the monitoring review, several psychiatry clinics were observed. The clinic scheduled for Dr. Brown conflicted with the timeframe of the neuropsychiatry clinic. This posed problems due to delaying Dr. Brown's attendance with the IDT for the other psychiatry clinic. The monitoring team elected to remain in the neuropsychiatric clinic with Dr. Brown, the PCP, and the neurologist, but the rest of the IDT was not present for this subspecialty integration meeting. The neuropsychiatry is discussed further in J15. Communication with the IDT and efficacy of running the clinic should be a function of the communication between the lead psychiatrist, medical director, psychiatric assistants, and IDT. Surprisingly, the medical director and the lead psychiatrist, did not express concern about the last minute change involving the neuropsychiatric clinic being held at the same time of the other psychiatric clinic. The monitoring team was informed by the medical director, Monday morning of the onsite visit, about the occurrence of the neuropsychiatric clinic because this was not on the formal schedule provided to the monitoring team. All treatment team disciplines were represented during each clinical encounter that was observed (except for the neuropsychiatric clinic). Further, the teams did not rush clinic,	

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		spending an appropriate amount of time (i.e., 30 minutes) with the individual and discussing the psychotropic treatment plan. For example, in the clinic conducted by Dr. Rao for Individual #429, Dr. Rao provided a concise overview of the individual's case history and presenting symptoms for this individual who was prescribed Geodon for mood stabilization. The team did a nice job providing the results of the objective measure (i.e., BPRS), was engaged with the psychiatrist, and receptive to Dr. Rao's request for data (i.e., sleep and appetite). The psychiatrist also suitably requested findings of the most recent ECG and stated the QTc was within normal range. The individual appeared to be very comfortable in the interaction with the psychiatrist and the IDT. There was even a discussion about community placement in a less restrictive setting. <u>Medication Management and Changes</u> 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. There are some psychiatric disorders, such as autistic disorder whereby medications have been utilized to target symptoms, such as self-injurious behavior. Additionally, if there is an exacerbation of an individual's bipolar disorder, medications would be appropriate to target aggression towards others or self-injurious behavior until stabilization occurred. • The consent process was in transition from the psychology department to the responsibility of the prescribing practitioner/psychiatrist that should result in clarification of the indication of the medication. • This provision item specifically requires that the IDT, including the psychiatrist, was to establish the expected timeline for the therapeutic effects of the medication for which the team has begun to address in the electronic QPMR. 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.	

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		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. <u>Monitoring Team's Compliance Rating</u> 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 found in the risk-benefit analysis, absence of case formulations, and inconsistent diagnostics. These deficiencies must be remedied 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.	<u>Policy and Procedure</u> Per DADS policy and procedure "Psychiatry Services" dated 8/30/11, "State Centers must provide education about medications when appropriate to individuals, their families, and LAR according to accepted guidelines…State Centers must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures." During the prior visit at MSSLC, the director of psychology reported 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. Both the medical and psychology departments were receptive to the prescribing physician being responsible for obtaining consent for psychotropic medication. The monitoring team was in agreement with this plan. Since the last visit, the psychiatrists were delegated to obtain consent for any new psychotropic medications ordered to start the transition of the duty from the psychology department to the medical/psychiatry staff. <u>Current Practices</u> The monitoring team was provided the new template via the completed consent for Individual #290. The first line of the consent form was not applicable and was representative of another template used for an intervention other than medication consent. • The opening sentence was that the psychiatrist recommended that Individual #290 "continue participation in/initiate a psychotropic drug regimen."	Noncompliance

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		The content of the form was appropriate in the listing of the medication (i.e., Risperdal) for the diagnosis of psychotic disorder, and a behavioral-pharmacological hypothesis of "delusional and disorganized thought content." Medication side effects as defined in the Physician Desk Reference (PDR) were summarized in categories of common, serious but rare, and very serious but rare. While this was progression, it would be helpful to list further detail, such as neuroleptic malignant syndrome with the symptoms associated with this syndrome, such as fever, muscle stiffness, unstable vital signs, etc. Other symptoms should also be relevant according to gender and not list, for example, "unwanted breast milk in females" for the male that was prescribed the medication. The consent should be personalized and not a cut and paste exercise. The expected timeline for the therapeutic effects of the medication to occur were listed as well as risks associated with receiving the medication. There was a section for the benefits associated with receiving the medication, alternatives to treatment, and potential consequences of lack of treatment. Lastly, the expiration of the consent was annually from the date of initiation. There was a signature line for the individual, representative signature with noted relationship to the individual, and date. It was vital for the facility to make certain of the legal status of the individual (i.e., competent major) and confirm the legal role of others when signing consents on the individual's behalf. For example, the consent form for Individual #290 listed the stepmother for the representative consenting to the medication being prescribed. It was not clear, based on the wording of the consent form if this individual was the responsible legal party. It is key for the legal information to be easily accessible (i.e., listed on every consent form and on each psychiatric consultation for easy reference) in regards to who is the responsible legal party for the individual receiving services at MSSLC inclusive of psychotropic medication. There would be a violation in the consent process if the representative signing the consent were not authorized. The new consent process as outlined above illustrated promise for the revision of this section. During the previous review, the form noted "Benefits and Risks of Program" had the same identical language for every medication, instead of the actual benefit and risks of each medication being cited. This had not improved. The repeated language for benefits and risks of the program was "Increase participation in Life, Social, and Training Activities and Improved Relationships with others." The name of several individuals were 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 Individual #560 and Individual #367 continued to be listed in the roster as receiving psychotropic medication when the LAR refused to	

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		authorize the treatment, according to the data presented to the monitoring team. 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 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> The facility was in the initial stage of addressing informed consent prior to administering psychotropic medication. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks. This provision remained in noncompliance due to the inadequate informed consent practices at MSSLC.	
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, Psychiatry Services dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the PST process, when the medications are prescribed to treat both seizures and a mental health disorder." Psychiatry Services Policy and Procedure, Medical #17, implemented 12/1/11 noted wording of the Settlement Agreement under the heading in integrated care. There was absence of a procedure to guide the IDT, neurologist, and psychiatrist to provide this neuropsychiatric integrated service to those identified individuals at MSSLC. <u>Individuals with Seizure Disorder Enrolled in Psychiatry Clinic</u> The monitoring team received a numbered alphabetized list of 53 individuals participating in psychiatry clinic who had a diagnosis of a seizure disorder. Last visit, there were 25	Noncompliance

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		individuals, a data difference of 28 individuals. This review period there was an improvement in 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. The psychiatry department was informed that it was imperative for this data to be identical with the pharmacy data in order to keep track of those in need of this service. The data provided by pharmacy from March, 2012-August, 2012 included a range from 54 to 58 individuals treated for a psychiatric disorder and seizures. <u>Adequacy of Current Neurology Resources</u> The scan call between the Scott & White Hospital Neurologist and MSSLC medical staff scheduled the week of the onsite review was cancelled the same day it was to occur, without any reason explained to the monitoring team. As noted during the last review, 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: the neurologist comes to MSSLC once a month, generally on a Monday. Since last monitoring review, clinics were conducted 5/14/12, 7/2/12, 8/20/12, and 9/24/12. Otherwise, the individuals were referred to an outside provider for a neurological evaluation (e.g., Scott and White physicians Drs. Kirmani, Borucki, or Creel). Now that the total number of individuals meeting this treatment intervention was calculated, the monitoring team determined that 20% of those enrolled in psychiatry clinic required a neuropsychiatric consultation through the IDT process. The psychiatrists stated that this was not able to be accomplished because of the others tasks to be completed. The monitoring team informed the psychiatry department that this evaluation could be one of the QPMRs if completed adequately with the neurologist and the IDT. These are the type of processes that the lead psychiatrist and medical director need to design in order to reduce redundant activities. A neuropsychiatric consultation required the participation of a neurologist and a psychiatrist through the IDT process. The drug regimen and drug interactions require a 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, it was obvious that the Settlement Agreement had not been explained to him or to the staff that were running the neurology clinic. The neurologist did not understand the reasons that the psychiatrist or the IDT should be present. The room provided for the neurologist was small and only allowed an area for the examination of the individual. It would be necessary to have an adequate meeting room because a quarter of those in	

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		psychiatry clinic required this clinical integration. It was imperative for the staff 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 monitoring team repeatedly witnessed the facility being unaware of the indications of the AED regimen and often thought it may have been prescribed solely for purpose of Axis I. The psychiatrist should educate the IDT and the neurologist of the need to monitor for a change in the mental status associated with seizure activity for individuals with a seizure disorder, especially those with intractable epilepsy. 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 defeated the whole purpose of the neurologist and the psychiatrist coordinating the use of medications. 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. Below are some additional comments: • 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 encouraged, due to the need for collaboration about how this may affect 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. • 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).	

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		Monitoring Team's Compliance Rating 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. The facility remained in noncompliance with this provision item due to the lack of implementation of a neuropsychiatric process for those identified in need of this intervention (i.e., identification of target symptoms for AED regimen that must occur between the neurologist and the psychiatrist).	

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 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 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. The facility must monitor the following in regards to pretreatment sedation and summarize data in one numbered list for the time period since the last review: a) individuals that received pretreatment sedation off-site for both medical and/or dental procedures inclusive of the names of the medications received for the procedure; b) dates of departure and return of the individual to MSSLC; c) results of the post-sedation monitoring by the medical staff upon return to the facility (J4).

9. Individualize the desensitization plans for dental and medical clinic. Implement cross-discipline consultation regarding pretreatment sedation options. The clinical pharmacist can provide the potential interactions of pretreatment sedation agents with concurrently prescribed medication to the IDT (J4).

10. 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.

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

12. 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 (J2, J8, J13).

13. Complete the comprehensive psychiatric evaluations following the requirements of the Settlement Agreement Appendix B. The psychiatry staff should utilize a consistent numeral system with similar categories in order to address all of the components as outlined in Appendix B (J6).

14. The facility to interpret percentages of completion of tasks since the last monitoring visit to mirror the report of the monitoring team as part of the self-assessment for all sections of J (J1-J15).

15. All lists and data submitted to the monitoring team must include a date, title, and department submitting the information on the document. (J1-J15).

16. 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).

17. The facility to address the deficits as outlined in the report regarding informed consent process for psychotropic medications. 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).

18. Formalization of the ISP process to include review of the risk/benefit ratios for the prescription of psychotropic medications and to be authored by psychiatry. Individualize the risk versus benefit for every one of the psychotropic medications prescribed, not one statement for numerous agents. The risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician, however, the success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data 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. 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 if the psychiatrist continues to utilize the medication in this situation. (J10).

19. 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, J13).

20. 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).

21. Revision of the psychiatry policy and procedure to reflect intended process within the neuropsychiatric clinic at MSSLC and in order to instruct the IDT about expectations of material to be presented to the neurologist and the psychiatrist (J15).

22. 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).

23. Consider the use of typed notes, projectors for clinical data review by the IDT during psychiatry meetings, and other means of making the psychiatric service provision more efficient (J2, J10, J13).

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Positive Behavior Support Plans (PBSPs) for: • Individual #591 (4/17/12), Individual #347 (3/26/12), Individual #436 (5/1/12), Individual #177 (3/23/12), Individual #137 (3/21/12), Individual #195 (4/16/12), Individual #127 (4/10/12), Individual #442 (7/18/12), Individual #211 (8/17/12), Individual #133 (9/12/12), Individual #217 (9/11/12) o Functional Assessments for: • Individual #61 (9/5/12), Individual #401 (8/2/12), Individual #367 (7/7/12) o Six months of progress notes for: • Individual #591, Individual #347, Individual #436, Individual #177, Individual #137, Individual #195, Individual #127, Individual #442 o Full Psychological Assessments for: • Individual #393 (4/10/12), Individual #337 (5/1/12), Individual #71 (5/10/12), Individual #384 (6/6/12), Individual #73 (6/7/12), Individual #290 (6/20/12), Individual #76 (5/8/12), Individual #614 (8/2/12), Individual #745 (8/2/12), Individual #850 (8/22/12) o Annual Psychological updates for: • Individual #264 (6/29/12), Individual #218 (7/31/12), Individual #424 (8/15/12), Individual #109 (8/20/12) o STARS-Group Counseling treatment plans for: • Individual #464, Individual #700, Individual #410, Individual #520, Individual #570, Individual #287, Individual #68, Individual #442, Individual #116, Individual #362, Individual #242, Individual #325, Individual #457, Individual #475, Individual #146, Individual #556, Individual #554, Individual #575 o STARS-Individual Counseling treatment plans for: • Individual #164, Individual #211, Individual #353, Individual #219 o STARS progress notes for: • Individual #146, Individual #556, Individual #554, Individual #575 o Psychology Department Weekly Data Collection form, dated 4/11 o Psychology Department IOA Monitoring Form, dated 1/12 o Inter-Observer Agreement Project presentation, undated o Peer/behavior review committee minutes for the past six months o List of dates of psychological assessments for all individuals, undated o List of all psychology staff and status of enrollment in BCBA coursework, undated o Minutes from psychology department meetings for the past six months o Graph of group therapy attendance for June-August 2012

	o Section K Presentation Book, undated o Section K Self-assessment, dated 9/6/12 o Section K Action Plans, dated 9/6/12 o List of all individuals with a PBSP, undated o Positive Behavior Support Plans at MSSLC Reading Level, undated o Functional Assessment Compliance Checklist o Structural and Functional Assessment Report template, undated o PBSP Compliance Checklist o Positive Behavior Support Plan template, undated o Psychiatry/Psychology Meeting agenda, dated 9/26/12 o List of all individuals receiving counseling, undated o Minutes of peer review committee meetings for the past six months o A list of training conducted on PBSPs, undated o Psychology BSP Competency Training Sheet, undated o Positive Behavior Support Plan Profile for: • Individual #309 <u>Interviews and Meetings Held</u>: o Charlotte Kimmel, Ph.D., Director of Psychology o Lupita Alfaro, Psychology Assistant o Psychology Department o Molly Chase, Psychologist o Polly Bumpers, John Parks, Troy Miller, Bertha Allen, and Rodney Price, Unit Directors <u>Observations Conducted</u>: o Behavior Therapy Committee Meeting • Staff Present: Charlotte Kimmel, Director of Psychology Services; Molly Chase, Psychologist; Nedra Francis, Assessment Psychologist; Xiaodong Zhang, Psychologist; Lupita Alfaro, Psychology Assistant; Andrew Griffin, Psychologist; Elizabeth Kadin, Psychologist; David Ehrenfeld, SLP; Ray Mathieu, BCBA • Individuals Presented: Individual #133, Individual #460, Individual #238, Individual #671, and Individual #349 o Substance Abuse Group Therapy session • Staff facilitators: Donna Porter, Psychologist; Kathy Robinson, Behavior Technician • Individuals participating: Individual #130, Individual #68, and Individual #575 o Clinical Psychology/Psychiatry Meeting • Charlotte Kimmel, Psychology; Andrew Griffin, Psychology; Xiaodong Zhang, Psychology; Temora Gray, Psychology; Nedra Francis, Psychology; Kendall Brown, Psychiatry; Madhu Rao, Psychiatry; Juanita Kirby, Psychiatry o Internal Peer Review Meeting • Staff Present: Michael Miller, Psychologist; Craig Biggar, Psychologist; Ray Matthieu, BCBA;

	Nedra Francis, Assessment Psychologist; Xiaodong Zhang Psychologist; Elizabeth Kadin, Psychologist; Tonya Russell, Psychologist; Charlotte Kimmel, Director of Psychology Services • Individual Presented: Individual #377 o Stars Task Force Meeting • Lupita Alfaro, Psychology Asst., Richard Boyer, Stars Program Director; Nedra Francis, Assessment Psychologist, Andrew Griffin, Psychologist; Lisa Jones, Psychology Assistant; Charlotte Kimmel, Director of Psychology Services; Molly Chase, Psychologist; Michael Miller, Psychologist; Craig Biggar, Psychologist; Temora Gray, Psychologist; Valerie McGuire, Consultant; Martha Mason, Doctoral Intern o Psychiatric Clinic • Individuals presented: Individual #429; Individual #45 o Positive Behavior Support Plan Training • PBSP for: Individual #309 • Staff conducting the training: Culetta Beachum, Psych Asst.; Kathy Robinson, Behavior Technician o Functional Assessment Training • Staff Presenting: Amy Dillree, BCBA-D • Staff Attending: Molly Chase, Psychologist; Michael Miller, Psychologist; Lupita Alfaro, Psychologist Assistant; Ray Matthieu, BCBA; Zuselle Quiles, Psychologist; Trey Stubbs, Psychologist, Gerry Reaves, Psychologist o ISPA Meeting • Staff present: Heather Malloy, QDDP; Rosanne Howard, RN; Donna Porter, Psychologist; Lupita Alfaro, Psychology Assistant • Individual presented: Individual #508 o Data Project Presentation • Staff present: Charlotte Kimmel, Director of Psychology Services; Lupita Alfaro, Psychology Assistant; Michael Miller, Psychologist; Ray Mathieu, BCBA; Richard Boyer, Stars Program Director; Molly Chase, Psychologist; Clint Dennard, Psychologist; Gerry Reaves, Psychologist; Donna Porter, Psychologist; Craig Biggar, 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: The self-assessment included many relevant activities in the "activities engaged in" sections. As suggested in the last review, however, the monitoring team believes that the self-assessment should include activities that are identical to those the monitoring team assesses as indicated in this report. For example, for K4, MSSLC's self-assessment included a review of interobserver agreement (IOA), a review of PBSPs that had been revised due to lack of progress, and the graphing of data; three topics that are included in the monitoring team's review of K4. The self-assessment, however, did not include several additional items that are necessary to achieve substantial compliance with K4 and are, therefore, included in the monitoring team's report. MSSLC's self-assessment also included several items that, although potentially important, are not included in the report. As the report below indicates, the critical items for K4 (and, therefore, the items that are suggested to 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) to address lack of progress. • Evidence that data are used to make treatment decisions in psychiatric clinics, peer review meetings, ISP meetings, etc. The monitoring team suggests that the psychology department 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, the action plans, and the monitoring team's report, are more likely to line up with each other. MSSLC's self-assessment indicated that three items (K2, K3, and K8) were in substantial compliance. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's self-assessment. The 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 suggest 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 are discussed in detail in this section of the report.
	Summary of Monitor's Assessment: Improvements since the last onsite review included: • Expansion of the collection of inter-observer agreement data (IOA) data (K4) • Improvements in data collection reliability (K4) • Improvement in the comprehensiveness of the full psychological assessments (K5) • Continued improvement in the establishment of evidence-based curriculums, goal directed services, and measurable treatment objectives for psychological therapies, other than PBSPs (K8) • The establishment of biweekly training of DCPs on the implementation of individual PBSPs (K12) The monitoring team suggests that the facility focus on the following areas during the next six months: • Continue to expand the collection of IOA data for target behaviors, establish IOA target levels, and ensure achievement of those levels (K4, K10) • Document the collection of data reliability, establish data collection reliability goals, and ensure that those levels are achieved (K4) • Increase the percentage of functional assessments completed for individuals with PBSPs (K5) • 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) include functional replacement behaviors and are based on the hypothesized function of the target behavior (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	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all psychologists at MSSLC who wrote Positive Behavior Support Plans (PBSPs) were certified as applied behavior analysts (BCBAs). At the time of the onsite review, one psychologist was a BCBA. Ten of the 14 psychologists who wrote PBSPs (71%) either had their BCBA, or were enrolled, or completed coursework toward attaining a BCBA. Three of the psychologists that were not enrolled or completed BCBA coursework had committed to begin coursework in the spring. This percentage of psychologists with their BCBA or enrolled in, or completed, BCBA coursework is slightly less than that reported in the last review (84%). 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. MSSLC and DADS are to be commended for their efforts to recruit and train staff to meet	Noncompliance

#	Provision	Assessment of Status	Compliance
	reasonable safety, security, and freedom from undue use of restraint.	the requirements of this provision item. The facility developed a spreadsheet to track each psychologist's BCBA training and credentials. To achieve substantial compliance with this provision item, the department needs to ensure that all psychologists who write PBSPs attain BCBA certification.	
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 35 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 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. In addition to the review of PBSPs requiring annual approval (i.e., Behavior Therapy Committee meeting), the internal peer review meetings provided an opportunity for psychologists to present cases that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #377's functional assessment. The peer review meeting included active participation from the majority of the department's psychologists, and appeared to result in a clearer understanding of the antecedents and consequences of Individual #377'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 continue to 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
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.	MSSLC made progress in this area. In order to achieve substantial compliance, however, the facility now needs to ensure that the multiple data systems provide sufficient information and are not confusing to staff, expand the collection of interobserver agreement (IOA) to all individuals with a PBSP, document data collection reliability, establish acceptable data collection and IOA levels, and ensure that those levels are achieved. In the last review, the facility had expanded the 60-minute target and replacement behavior data system to all individuals and homes at MSSLC. Recently, this system was modified to only recording target and replacement behaviors once a shift in some homes (e.g., M2). Other homes appeared to have different data systems for different individuals (L1). The use of multiple data systems that are flexible to individual data needs (e.g., very low frequency behaviors) can improve the usefulness of a data system. Reducing the number of measurement intervals of target and replacement behaviors, however, could result in the loss of critical information (e.g., important patterns of behavior as discussed in Individual #367's functional assessment, see example below and in K5), and could be confusing for staff (particularly in homes where multiple data systems exist). In future reviews, these issues, including available reliability data, will be evaluated to determine the acceptability of these new, and multiple, data systems. In all of these data systems, 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 (in the systems with multiple intervals per shift) 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 were very encouraging: • The target and replacement behaviors sampled for nine of 13 data sheets reviewed (69%) were completed up to the previous hour. This was considerably better than the last review when only 17% of the data sheets were recorded up to the previous hour. One reason that data collection reliability may have improved is that several psychologists reported that they had been reviewing data in their homes and providing performance feedback to DCPs. It is recommended that the facility document attempts to collect this 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. As discussed in the last review, the facility had begun to collect inter-observer agreement (IOA) data. At the time of the onsite review, IOA was being collected in four of the five units at MSSLC. Additionally, the self-assessment indicated that the average IOA for the last five months was 75%. 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 improvement at MSSSLC was the flexibility in 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 elopement data were graphed in hourly increments to better identify a potential pattern in his target behavior. Additionally, as recommended in the last report, all the graphs reviewed by the monitoring team were simplified by reducing the number of data paths and adding of phase lines to mark medication changes and/or other potentially important events. The routine use of data to make treatment decisions was also improving at MSSLC, however there continued to be room for improvement. For example: • In Individual #45's psychiatric clinic observed, the psychologist presented a simplified graph of target and replacement behaviors. Additionally, a potentially important event, moving to a new home, was clearly marked with a phase line on the graph and guided the team to conclude that the move resulted in a dramatic decrease in Individual #45's target behavior. It was also discussed, however, that a medication change had occurred at the same time as the move, and it may be responsible for the improvement in behavior. Including all potentially important events on the graph is critical for assisting the team in making data based decisions. • In Individual #429's psychiatric clinic the team was discussing the effects of a recent medication change. A simplified graph was presented, however it did not include the last three weeks of data, and therefore the team could not make a data-based decision on the effects of the medication on his behavior. Current graphed data is very important for ensuring data based medication decisions.	

#	Provision	Assessment of Status	Compliance
		In order to achieve substantial compliance with this provision item, the psychology department needs to ensure that all treatment decisions are data based. Specifically, the facility needs to demonstrate the value of data by ensuring it is current and reliable, and consistently graphing and presenting data in increments that encourage data based treatment decisions. In reviewing at least six months of PBSP data of severe behavior (e.g., physical aggression, self-injurious behavior) for nine individuals, five (Individual #217, Individual #133, Individual #436, Individual #127, and Individual #211), or 56%, indicated no obvious improvement in severe behavior. This was consistent with the last review when 58% of the individual's reviewed showed no obvious improvement in severe behavior. There was, however, some indication that when progress was not occurring, action was taken to address the lack of progress. For example, the self-assessment indicated that four PBSPs were modified in the last six months to address lack of progress. The monitoring team encountered one of those plans (Individual #436). Clearly, the lack of treatment progress is not likely to be solely the result of an ineffective PBSP, however, the monitoring team does expect that the progress note or PBSP would indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred if an individual was not making expected progress. The monitoring team will continue to monitor the progress of target behaviors as one measure of the effectiveness of PBSPs, and behavior systems in general, at the facility. The monitoring team recognizes the progress the facility was making on this provision item, and encourages the psychology department to continue their efforts in this area.	
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 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 the functional 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 214 of the 369 individuals at MSSLC (58%) had a full psychological assessment. Each individual's record should contain a full psychological assessment that consists of an assessment or	Noncompliance

#	Provision	Assessment of Status	Compliance
		review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status. The self-assessment indicated that 12 full assessments were completed in the last six months. Ten of these 12 full assessments (83%) were reviewed to assess compliance with this provision item: • All 10 of the full psychological assessments reviewed (100%) 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 represented an improvement from the last review when 73% of assessments reviewed were complete. <u>Functional Assessments</u> At the time of the onsite review, 51 of the 307 individuals with a PBSP (17%) had a functional assessment. All individuals with a PBSP should have a functional assessment of the variable or variables affecting their target behaviors. A list of all functional assessments indicated that three were completed since the last review. All three of those functional assessments (100%) were reviewed to assess compliance with this provision item. 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 three of the functional assessments reviewed included acceptable indirect assessment procedures. Two of the three functional assessments reviewed (67%) were judged to contain adequate direct assessment procedures. This represented a slight decline from the last review when 100% of direct observation procedures were judged to be acceptable. An example of a complete direct assessment procedure is described below: • Individual #367's functional assessment included an analysis of attempts to elope from the facility. This functional assessment analyzed several potential antecedents to determine if the behavior was more likely to occur at particular times of the day, days of the week, or following specific activities/events. This direct assessment revealed that Individual #367's elopement attempts were most likely to occur when he was asked to terminate a preferred activity and when a preferred staff was not working with him.	

#	Provision	Assessment of Status	Compliance
		One of the functional assessments reviewed (i.e., Individual #61) did not include a direct assessment procedure. All functional assessments should include direct functional assessments that include target behaviors and provide additional information about the variables affecting the target behavior. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This 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. Two (i.e., Individual #367, Individual #61) of the three functional assessments reviewed (67%) were judged to have a clear summary statement. This represented a slight decrease in acceptable summary statements from the last report when 80% were found to have a clear summary statement. Individual #401's summary statement was confused by the inclusion of a table in which terminology was used incorrectly (e.g., establishing operations, abolishing operations). All functional assessments should include a summary statement that integrates the results of the various assessments into a clear and 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 (e.g., Individual #367). A list of functional assessments indicated that 11 additional functional assessments were revised at least once since they were originally written, however, nine of those were more than one year old. 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. One (Individual #367) of the three functional assessments reviewed (33%) was evaluated to be comprehensive and clear. This represented a decline over the last report when 80% of the functional assessments reviewed were evaluated as acceptable.	

#	Provision	Assessment of Status	Compliance
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 full psychological assessments were not 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 full psychological assessments indicated that 120 of the 214 (56%) were not conducted in the last five years. This represented a slight decrease from the last report when 63% of the full psychological assessments were conducted within five years. Full psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	In addition to the 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 and risk evaluations) were completed for 47 of the 369 individuals at MSSLC (13%). This represented an improvement from the last review when 5% of individuals had annual psychological assessments. Thirty annual assessments were completed since the last review and four (13%) were reviewed by monitoring team to assess their comprehensiveness: • Two annual psychological assessments (i.e., Individual #218 and Individual #424) were 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 • The other two annual assessments (i.e., Individual #264 and Individual #109) were missing 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 that contain 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. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that this component of this provision item continued to be in compliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	Psychological services, other than PBSPs were provided at MSSLC. This was an area in which the facility had made improvements in the last two reviews. These improvements have resulted in substantial compliance with this provision item. At the time of the onsite review, MSSLC offered six group therapies and individual therapy. One hundred and seventy-nine individuals were actively receiving therapy at the time of the onsite review. Twenty-three treatment plans (13%) and three progress summaries were reviewed to assess compliance. Additionally, the monitoring team observed a group therapy session. All treatment plans reviewed were found to be goal directed, with measurable objectives, specific treatment expectations, and appeared to be derived from evidence-based practices. They also contained an objective review of progress, and each treatment plan reviewed included a "fail criterion" and a plan for the generalization of acquired skills. Observations of group therapy indicated that there was a clear objective for each class, and measurable progress toward that goal was recorded. Staff who provided therapeutic interventions were qualified to do so through specialized training, certification, or supervised practice. Staff who assisted in therapy, or who supervised homework or milieu activities, received training and monitoring from qualified therapists. MSSLC has achieved substantial compliance with this provision item. In order to maintain substantial compliance the facility will need to demonstrate that all therapies, other than PBSPs, continue to be goal directed, with measurable objectives, specific treatment expectations, and objective measures of progress. Additionally, the facility will need to demonstrate that their therapies are evidence based and steps have been taken (e.g., attended conferences, workshops, modified curriculums) to ensure that all therapies represent current best practice.	Substantial Compliance
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and	This item was rated as being in noncompliance because PBSPs reviewed did not consistently contain adequate use of all of the components necessary for an effective plan. A list of individuals with PBSPs indicated that 307 individuals at MSSLC had PBSPs, and 198 of these were completed since the last review. Eleven (6%) of these 194 PBSPs were reviewed to evaluate compliance with this provision item. All 11 of the PBSPs reviewed had the necessary consent and approvals.	Noncompliance

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	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.	All PBSPs reviewed included descriptions of target behaviors, however, one (Individual #442's) of these was not operational (9%). This represented a slight decrease from the last review when all PBSPs reviewed contained operationally defined target behaviors. The reason Individual #442's target behaviors were not rated as operational is highlighted below: • Individual #442's PBSP defined stealing as "Knowingly taking someone else's belongings…" This definition required the reader to infer if Individual #442 knew the item belonged to someone else. An operational definition should not require DCPs to infer an individual's knowledge or intentions. An operational definition should only include observable behavior. An example of a well written operational definition was: • Individual #137's target behavior of stealing that was defined as "…taking items without permission that do not belong to him…." All PBSPs should include operational definitions of target behaviors. All 11 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but three (i.e., Individual #591, Individual #347, and Individual #436's) of these (27%) 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 was consistent with the last two reports when 23% and 27% of antecedent and/or consequent procedures were judged to be inconsistent with the stated function. An example of a consequent intervention potentially incompatible with the hypothesized function was: • Individual #591's PBSP hypothesized that his physical aggression was maintained by negative reinforcement (i.e., a way to escape or avoid undesired activities). His PBSP, however, included directing him to his room following physical aggression. If avoiding undesired activities was reinforcing for Individual #591, then this intervention would likely increase the likelihood of his disruptive behavior. Ideally, after the targeted behavior occurred, Individual #591 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.	

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		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 #217'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., asking staff to talk or play a game). His intervention following aggression included ensuring others safety, however minimizing staff attention until the aggression ended and he demonstrated calm behavior. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and based on the identified function of the target behavior. 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 five (i.e., Individual #591, Individual #436, Individual #177, Individual #442, and Individual #133) of the 11 PBSPs with replacement behaviors that could be functional (45%). This represented a decrease from the last two reports, when 25% and 30% of all replacement behaviors that could be functional were not functional. An example of a replacement behavior that was not functional was: • Individual #177's PBSP hypothesized that his rage reaction was maintained by both positive and negative reinforcement. His replacement behavior was compliance with requests. These behaviors were incompatible with his target behavior and, therefore, likely an appropriate goal for Individual #177, however, it did not appear to be functional. Examples of a functional replacement behavior could include teaching/reinforcing another way to escape or avoid unpleasant activities, (such as asking for a break) or attain attention (such as asking to talk to staff). All 11 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 #127's replacement behavior included engaging others in	

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		conversation. The PBSP included instructions for staff to encourage Individual #127 to appropriately interact with others. Based only on the reading of the PBSP, the monitoring team can only speculate as to if these replacement behaviors were in the individual's repertoire, or if they required the acquisition of a new behavior. The purpose of introducing this distinction is that when the replacement behavior requires the acquisition of a new behavior, it should be written in the new format skill acquisition plan (SAP, see S1). Overall, five (Individual #137, Individual #195, Individual #127, Individual #211, and Individual #217) of the 11 PBSPs reviewed (45%) 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 a decrease from the last review when 64% 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 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.	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. 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. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	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 had 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 increase the	Noncompliance

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		likelihood that they could be understood by DCPs. The self-assessment indicated the average reading level of PBSPs at the facility was 9.24, which represented a slight improvement from the 9.62 average reading level reported in the last report. 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 that PBSPs are understood and implemented as written, however, is to implement a system to monitor treatment integrity. It is recommended that an effective treatment integrity system be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	This is another area where the facility made improvements since the last review. The psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. Psychologists and psychology assistants conducted the trainings prior to PBSP implementation and whenever plans changed. Additionally, the facility recently added scheduled biweekly trainings of DCPs on the implementation of Individual PBSPs. At the time of the onsite review, however, there was no competency-based training component, and there was no systematic way to identify all of the staff who required remedial training. Therefore, this item is rated as being in noncompliance. The director of psychology indicated that she believed a psychologist or psychology assistant had trained all staff implementing PBSPs on the use of that plan. The exception being staff "floated" from another home. Those staff, however, were reportedly trained in the implementation of the PBSP by the home supervisor. The monitoring team observed the training of DCPs on Individual #309's PBSP. The training included a review of the PBSP by the psychologist, an opportunity for DCPs to ask questions, and written and oral questions covering varying aspects of the PBSP. The training did not, however, include a competency based training component that allowed the psychologist to observe the staff implementing the plan, and an opportunity for the psychologist to provide performance feedback to the DCPs. 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 (including float staff) has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter. Additionally, there needs to be evidence that the training included a competency-based component. Finally, the facility should track DCPs who require remediation, and document that they	Noncompliance

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		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 369 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:

Recommendations:

1. Ensure that all psychologists who are writing Positive Behavior Support Plans (PBSPs) attain BCBA certification (K1).
2. The facility should document data collection reliability for all target and replacement behaviors collected in each residence and day/vocational site. Additionally, 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. Ensure that all treatment decisions are data based (K4).
5. If an individual is not making expecting progress, the progress note or PBSP should indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4).
6. All individuals should have a full psychological assessment (K5).
7. All individuals with a PBSP should have a functional assessment of the variable or variables affecting their target behaviors (K5).
8. All functional assessments should include direct functional assessments that include target behaviors and provide additional information about the variables affecting the target behavior (K5).
9. All functional assessments should include a summary statement that integrates the results of the various assessments into a clear and comprehensive statement of the variables affecting the target behaviors (K5).

10. It is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that it be included in a revision of the functional assessment (with a maximum of one year between reviews) (K5).

11. Full psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K6).

12. All individuals should have annual psychological assessments that contain 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 (K7).

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

14. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and based on the identified function of the target behavior (K9).

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

16. It is recommended that an effective treatment integrity system be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established (K11).

17. The facility needs to provide documentation that all staff assigned to work with an individual (including float staff) 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).

18. Revise the self-assessment so that it includes the topics that the monitoring team commented upon in the report (self-assessment).

19. Establish six-month goals to focus upon for the next onsite review (self-assessment).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009.2: Medical Care, 4/19/12 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 DADS Clinical Guidelines o MSSLC Policy and Procedure Medical #24 Preventive Health Care Guidelines, 5/17/12 o MSSLC Policy and Procedure Medical #21 Pharmacy Services, 9/13/12 o MSSLC Policy and Procedure Medical #25 Urinary Tract Infection Protocol, 7/19/12 o MSSLC Policy and Procedure Medical #26, Guidelines for Constipation Management, 7/19/12 o MSSLC Policy and Procedure Medical #27, Osteoporosis Guidelines, 7/19/12 o MSSLC Policy and Procedure Medical #Guideline's for Seizure Management, 7/19/12 o MSSLC Lab Matrix o Infection Control Committee Meeting Minutes, 2012 o Pneumonia Review Notes o Clinical Daily Provider Meeting Minutes, March 2012 – August 2012 o Medical Review Committee Meeting Minutes, March 2012 – August 2012 o Quality Assurance Reports June, July, and August 2012 o Listing of Medical Staff o Medical Caseload Data o Medical Staff Curriculum Vitae o Primary Provider CME Data o PA Collaborative Agreement o Medical Department Employee CPR Data o Copies of PCP InServices on ICD and DSM Diagnostic Criteria o Mortality Review Documents o Avatar Pneumonia Tracking Forms o Clinic Tracking Log o Reports for Internal and External Medical Reviews 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 with diagnosis of malignancy, cardiovascular disease, diabetes mellitus, hypertension, sepsis, and GERD o Listing, Individuals hospitalized and sent to emergency department 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, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, MARs, annual nutritional assessments, dental records, and annual ISPs, for the following individuals: • Individual #266, Individual #9, Individual #215, Individual #369, Individual #477 Individual #61, Individual #17, Individual #38, Individual #80, Individual #266 o Annual Medical Assessments the following individuals: • Individual #476, Individual #221, Individual #600, Individual #493, Individual #567, Individual #100, Individual #133, Individual #99, Individual #265, Individual #575, Individual #589, Individual #54, Individual #38, Individual #296, Individual #444 o Neurology Notes for the following individuals: • Individual #65, Individual #109, Individual #337, Individual #64, Individual #9, Individual #156, Individual #155, Individual #146, Individual #468 o Consultation Referrals and IPNs and for the following individuals: • Individual #331, Individual #100, Individual #411, Individual #303, Individual #570 Individual #21, Individual #248, Individual #61, Individual #381 <u>Interviews and Meetings Held</u>: o Dolores Erfe, MD, Medical Director o Angela Johnson, RN, Medical Compliance Nurse o Chris Ellis, MD, Primary Care Physician o Bernardo Gutierrez, MD, Primary Care Physician o James Gilley, MD, Primary Care Physician o Kendall Brown, MD, Lead Psychiatrist o Madhu Rao, MD, Staff Psychiatrist o Juanita Kirby, MD, Staff Psychiatrist o William Thomas, PA o Norris Buchmeyer, Chief Nurse Executive o Karen Wilson, RN, QA Nurse o Anyssa Garza, PharmD, Pharmacy Director o Esteban Rodriguez, PharmD, Clinical Pharmacist o Abigail Okeke, PharmD, Clinical Pharmacist <u>Observations Conducted</u>: o Daily Clinical Services Meetings o Medical Review Committee Meetings o Neurology Clinic for Individual #215

	o Observations of homes o Informal observations of medical clinics/rounds
	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) the provision action information. The self-assessment was overall inadequate and it appeared that very little effort was involved in the process. For example, for Provision L1, the medical director cited compliance rates for annual and quarterly summaries then concluded that the facility was noncompliant. For Provision L3, compliance rates for cancer screenings and osteoporosis management were listed as greater than 90%, but the self-rating was noncompliance. There appeared to be no connection between what was assessed, the results, and the self-rating. There were many areas that the monitoring team assessed that were not included in the self-assessment, such as staffing, the provision of neurological services, and physician participation in the team process. It is important that the self-assessment include all of the areas reviewed by the monitoring team. Overall, there was no improvement in the assessment process even though previous monitoring reports had given recommendations on how to proceed. During the conduct of this review, the monitoring team met with the medical director and medical compliance nurse and reviewed each provision item noting those areas assessed and included in the report. 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. The self-assessment, similar to the monitor's 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 all four provisions. The monitoring team concurred with the facility's self-rating.
	Summary of Monitor's Assessment: The medical department made some progress in the provision of medical services. This was largely based on the strength of a few long term and very capable members of the primary care medical staff. The department, however, appeared to be in a state of disarray and was incapable of demonstrating the progress that was made. For example, numerous local policies were recently developed related to state issued guidelines, but none of those were submitted to the monitoring team in the document request as required. Due to the dearth of apparent development of clinical guidelines, policies, and procedure, the

	monitoring team made an emphatic request again for the facility to submit any and all policies and procedures. Only then, did the medical department submit several polices that were developed. While the unapproved version of the policies were found inserted in the back of the presentation binder, the medical director made no efforts to highlight these during multiple interviews. Data management remained problematic and many document requests were simply not fulfilled or inadequately fulfilled noting that the person responsible for data was on sick leave. Moreover, there continued to be issues related to calculating data for compliance rates such that compliance rates appeared higher than they actually were. In many instances, spreadsheets had no headings, rendering the data useless. Lists, such as those individuals with the diagnosis of pneumonia, were incomplete and lacked essential information, such as the obvious date of the diagnosis. The osteoporosis data remained inaccurate based on the data found through record reviews. Consultation data related to three separate questions were inappropriately averaged resulting in an inaccurate assessment of the facility's status. This disorganization in the department was manifested during the compliance visit as well. The monitoring team was not informed that the onsite neurology clinic was being conducted nor was the monitoring team informed when events were cancelled. Unfortunately, there was also a failure to maintain a reasonable sense of order in some meetings attended by the monitoring team. In terms of the provision of medical care, the facility continued to have good compliance with immunization administration, vision and hearing screenings, and some preventive care. Compliance with some cancer screenings increased. Documentation of care varied with long-term providers showing greater compliance. Seizure management was a cause for concern at MSSLC. There was no adequate forum for neurology-psychiatry clinic and the neurologist conducting the onsite clinic had little to no knowledge of any of the issues specified in the Health Care Guidelines. It would indeed be difficult to gain compliance with the requirements, such as reviewing the MOSES and DISCUS evaluations, without knowing that this was necessary. Additionally, record reviews indicated that seizure-free individuals were not considered for tapering of medications. The facility made no progress in the development of a medical quality program and there appeared to be little enthusiasm for doing so. The record request indicated there was no evidence and the monitoring team found this to be accurate. Localized policies were developed for several of the state issued protocols, but it did not appear that the medical staff received information on the newly developed policies and procedures. Overall, while the lack of organization, leadership, and solid systems had an untoward impact on the progress see at MSSLC, there was evidence that some providers were rendering good care that was beneficial to individuals living at MSSLC. The facility's physician assistant was observed during this review, as during previous reviews, to be extremely knowledgeable about his caseload and provide good care. The records reflected this care. This finding was also noted by external medical reviews. MSSLC depended

	heavily on a rotating medical staff. It is, therefore, particularly important that the systems for the delivery of medical care are well developed and thoroughly implemented. This will allow rotating providers to step in and assume care while minimizing gaps in continuity.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	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 above documents reviewed list. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in subsections 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 75 with the largest being 94. The largest caseload of 94 belonged to the PCP who provided care to the most medically fragile and sickest individuals residing at MSSLC. This appeared to be an odd finding. The medical director stated that this caseload structure was a mandate of state office. 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. The medical program compliance nurse continued to report directly to the medical director. **Physician Participation In Team Process** The facility continued the daily 8:30 am clinical services meetings. 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 and attend the various meetings. The medical department maintained data on physician attendance at ISP meetings. These data were based upon required meetings only. For the months of June, July, and August 2012, the overall participation by the medical staff was 40%, 19%, and 26%, respectively. These data also reflected several months of zero participation by several providers in mandatory annual IDT plannings and other required meetings. MSSLC cannot achieve substantial compliance with integration of clinical services given such	Noncompliance

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		dismal participation by the medical staff. It is, therefore, imperative that the facility director and medical director understand the root of this problem. The medical director reported that the caseload structure was issued by state office. This structure resulted in one physician having responsibility for 94 of the most medically fragile individuals. This physician had zero attendance at required meetings during July 2012 and August 2012. The medical director cited increased workload as the reason. The monitoring team believes that the caseload structure should be re-evaluated with consideration given to distribution of workload as well as stability of staff. **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. Neurology clinic was conducted onsite each month for 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 via the on-call MD. The facility maintained a hospital liaison program through nursing services. There were no changes in the provision of laboratory and x-ray 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 with most doing an adequate job and some providing very good care. The various sections of this report will 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.	

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		Annual Medical Assessments Annual Medical Assessments included in the record sample as well as those submitted by the facility were reviewed for timeliness of completion as well as quality of the content. For the Annual Medical Assessments included in the record sample: • 9 of 10 (90%) AMAs were current • 4 of 10 (40%) AMAs included comments on family history • 7 of 10 (70%) AMAs included information about smoking and/or substance abuse history • 0 of 10 (0%) AMAs included information regarding the potential to transition The facility submitted a sample of 15 of the most recent Annual Medical Assessments along with a copy of the previous year assessment. For the sample of Annual Medical Assessments submitted by the facility: • 15 of 15 (100%) AMAs were completed in a timely manner. • 11 of 15 (73%) AMAs included comments on family history • 15 of 15 (100%) AMAs included information about smoking and/or substance abuse history • 0 of 15 (0%) AMAs included information regarding the potential to transition The QA report documented 96% compliance for timely completion of annual assessments for the months of March 2012 through August 2012. The format of the AMAs evolved with the more recent documents showing improvements. Many providers provided nice narratives that summarized the past year of events and most were adequately summarizing the plans of care. None of the AMAs included transition plans. That was true even for Individual #215 who reported during his clinic neurology appointment that he had visited a community home he was considering moving to. Quarterly Medical Summaries The medical department recently adopted a template for completion of Quarterly Medical Summaries. For the records contained in the record sample: • 4 of 10 (40%) records included at least one QMS for the past two quarters • 6 of 10 (60%) records did not include a QMS for the past two quarters	

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		Compliance with this requirement was very provider specific. Long-term providers had better compliance with this requirement. For the QMSs that were reviewed, the content and format was good. The facility's self reported data indicated that overall compliance for June, July, and August 2012 was 54%. <u>Active Problem List</u> For the records contained in the record sample: • 10 of 10 (100%) records included an APL • 4 of 10 (40%) documents were adequately updated The Active Problem Lists were identified in all records included in the sample. Several of the documents did not include recent diagnoses or had inaccurate diagnoses. The problem lists should be updated as problems arise and/or resolve. Examples of issues related to APLs were found in the records of Individual #17, Individual #9 and Individual #38. <u>Integrated Progress Notes</u> Physicians generally documented in the IPN in SOAP format when the entry involved a clinical encounter. The notes were usually signed and dated. Some providers produced notes electronically, which was good to see because it removed all issues related to legibility of the notes. Pre-hospital notes were frequently not found, but many transfers occurred after hours. Post-hospital documentation was improved. Providers also increased documentation of the results of diagnostics, such as labs and x-rays and consultation recommendations. Many of these findings were very provider specific. The monitoring team noted that long-term providers tended to have better documentation. <u>Physician Orders</u> Generally, the medical staff did a good job in writing physician orders. Most were dated, timed, signed and included the essential elements of a physician order. Verbal orders were usually cosigned. Legibility of orders was problematic for some providers and the medical director should address this issue. <u>Consultation Referrals</u> The facility implemented a database to track consults. The consults and IPNs for eight individuals were requested. A total of 48 consults completed after March 2012 (including those from the record sample) were reviewed: • 29 of 48 (60%) consultations were summarized by the medical providers in the IPN within five working days; all of the consults reviewed were initialed and dated by the medical providers indicating review of the consults.	

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		Providers summarized the recommendations of the consultants and stated agreement or disagreement with the recommendations. In was noted that only one provider consistently documented the decision to refer or not refer the recommendations to the IDT. This provider was the only provider to utilize the attachment, which noted agreement or disagreement and IDT referral. The Settlement Agreement requires that medical providers review and document whether or not to adopt the recommendations and whether to refer the recommendations to the IDT for integration with existing supports. The current Health Care Guidelines mandate that IPN documentation occur within five working days of receipt and that the IPN documentation include an explanation when the provider disagrees with the recommendations. The monitoring team, therefore, recommends that documentation occur within the required timeframe, include agreement or disagreement, as well as the decision related to IDT referral. Additionally, an appropriate and clinically justifiable rationale should be provided when the recommendations are rejected. It is further recommended that that the PCPs notify the IDT when there is a disagreement with the recommendations of the consultant because further discussion may be warranted. The monitoring team also recommends that, for every IPN entry, the medical provider indicate the type of consultation that is being addressed as well as the date of the consult (e.g., Surgery Consult, 1/1/12). Consultation referrals are discussed in further detail in section G2. **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. Recently completed AMAs included documentation of immunization status. Compliance with cancer screenings remained steady with a small increase noted in colorectal cancer screening and a small decrease in the number of males with current PSA studies. The application of the cervical cancer screening appeared problematic as the medical director interpreted the Health Care Guidelines to mean cervical cancer screening was done every three years on essentially all females. Preventive care services, such as cancer screenings and osteoporosis, were tracked in databases. As previously noted, the monitoring team had some concern about the integrity and accuracy of data generated by the medical department. Data from the 10 record reviews listed above and the facility's preventive care reports (databases) are summarized below:	

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		Preventive Care Flow Sheets For the records contained in the record sample: • 10 of 10 (100%) records included PCFSs • 0 of 10 (0%) forms were signed and dated The Preventive Care Flowsheets were found in all of the records reviewed. The form was revised and the revision represented an improvement. There was no indication who completed the form and most forms had additional information, such as labs and diagnostics, scribbled on the margins. Most of the forms were also not currently updated. None of the forms reviewed were signed or dated by the medical provider even though a space was provided for this. Immunizations • 9 of 10 (90%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations • 9 of 10 (90%) individuals had documentation of varicella status. One individual refused multiple vaccinations. Screenings • 8 of 10 (80%) individuals received appropriate vision screening • 8 of 10 (80%) individuals received appropriate hearing testing Prostate Cancer Screening • 4 of 6 males met criteria for PSA testing • 3 of 4 (75%) males had appropriate PSA testing A list of males greater than age 50, plus African American males greater than age 45, was provided. The list included 71 males: • 59 of 71 (83%) males had current PSA results documented • 12 of 71 (17%) males were overdue for PSA testing Breast Cancer Screening • 3 of 4 females met criteria for breast cancer screening • 1 of 3 (33%) females had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 57 females, the date of the last mammogram, and explanations for any lack of testing: • 36 of 57 (63%) females had current breast cancer screenings • 13 of 57 (23%) females did not have current screenings • 8 of 57 (14%) females had no documentation of breast cancer screenings.	

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		Cervical Cancer Screening • 4 of 4 females met criteria for cervical cancer screening • 3 of 4 (75%) females completed cervical cancer screening within three years A list of females age 18 and older was provided. The list included the names of 67 females, the date of the last pap smear, and explanations for lack of testing: • 30 of 67 (45%) females completed cervical cancer screening in 2012/2011 • 19 of 67 (28%) females completed cervical cancer screening in 2009/2010 • 7 of 67 (11%) females completed cervical cancer screening prior to 2009 • 11 of 67 (16%) females had no documentation of cervical cancer screening The medical director should review these data along with the requirements for cervical cancer screening to ensure that the requirements are being applied appropriately. A thoughtful risk/benefit analysis should be documented in the records to explain the approach to screening. Colorectal Cancer Screening • 7 of 10 individuals met criteria for colorectal cancer screening • 5 of 7 (71%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list contained 114 individuals: • 71 of 114 (62%) individuals had completed colonoscopies • 43 of 114 (38%) individuals had not completed colonoscopies Additional Discussion The monitoring team recommends that the medical providers thoroughly document the discussion to discontinue or not complete required screenings. This documentation should include a risk/benefit assessment as well as the discussion with the individual/LAR and the IDT. **Disease Management** The facility implemented numerous clinical guidelines based on state issued clinical protocols. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. Data derived from record audits and the facility reports are summarized below.	

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		Pneumonia The document request included a list of individuals with pneumonia, however, this list was not consistent with what was documented in the hospital tracking logs. The monitoring team was referred to the nursing department for additional data. The minutes of the pneumonia review meeting were provided with the last set of minutes being dated May 2012. The information for individuals who experienced pneumonia in July 2012 and August 2012 was, therefore, not included. Each month, pneumonia cases were discussed in the Medical Review Committee. Information for each individual included hospital dates, x-ray findings, labs, culture results, feedings, GERD/dysphagia status, medications, risk factor review, and disposition. For the cases reviewed, it appeared that this multidisciplinary group, which included the medical staff, dietician, respiratory and habilitation services, made an effort to consider alternative treatments. For example, in the case of Individual #188 it was noted that aspiration was related to vomiting and other GI issues. The gastric tube was, therefore, replaced with a gastro-jejunal tube in an effort to partially diminish this. The monitoring team recommends that the medical director develop localized guidelines for the management of pneumonia and aspiration pneumonia using the state issued protocols as the framework. This will be important in management and in assessing how the faculty is providing care to those with the diagnosis of pneumonia. Osteoporosis • 7 of 10 individuals were diagnosed with osteoporosis • 5 of 7 (71%) individuals received treatment with Vitamin D and/or calcium • 7 of 7 (100%) individuals received additional pharmacologic therapy (Reclast/Alendronate) • 7 of 7 (100%) individuals had documentation of BMD A list of 79 individuals with the diagnosis of osteoporosis was provided. For those 79 individuals with a diagnosis of osteoporosis: • 27 of 67 (40%) individuals received treatment with Reclast • 32 of 67 (48%) individuals received Alendronate • 10 of 67 (15%) individuals received treatment with other pharmacologic therapies • 49 of 79 (62%) individuals completed DEXA scans between 2010 and 2012 • 1 of 79 (7%) individuals completed DEXA scans in 2009 • 19 of 44 (43%) individuals had no documented DEXA scans	

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		The majority of individuals included in the record review who had the diagnosis of osteoporosis did not have medications accurately listed on the osteoporosis listing. The medical director and medical compliance nurse should review this data set and develop a system to ensure accuracy of data. **Case Examples** Individual #80 • This individual was diagnosed with colon cancer. At the age of 60, the individual underwent a screening colonoscopy for the first time. A 4 cm fungating mass was identified which was an adenocarcinoma of the proximal colon. The individual subsequently underwent a hemicolectomy. This case highlights the significance of early colonoscopy in the prevention of colon cancer. Individual #17 • This individual started dialysis in March 2012. A consult from the transplant team indicated that the individual was an acceptable candidate for transplantation, but there was concern about social support and guardianship. A note from the PCP in May indicated that a social services consult was warranted, but further documentation regarding discussion of transplantation was not identified in the records provided. Individual #266 • This individual was noted to have an iron deficiency anemia. A colonoscopy was ordered as part of the required workup and the individual was noted to have a benign polyp (perhaps contributing to anemia). This case again highlights the value of utilizing colonoscopy appropriately. **Seizure Management** The lack of provision of data and information related to neurological services somewhat impeded evaluation of this area. A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 109 individuals. The specific AED polypharmacy data were not provided as requested nor were specific data submitted for those with a diagnosis of refractory seizure disorder and a history of status epilepticus. Data related to outside neurology clinic appointments were not clear, due to the fact that the table listed multiple dates, but lacked headings to indicate the significance of the dates. The monitoring team requested neurology consultation notes for the past 12 months for	

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		10 individuals. Notes for nine individuals were submitted. These individuals are listed in the above documents reviewed section. The facility submitted a single neurology clinic note for each of the nine individuals. Two of the nine individuals were evaluated for issues not related to seizure management. The monitoring team could not determine if each individual received additional care based on this submission. All nine evaluations occurred at the onsite clinic. The clinic notes were largely illegible, but it was clear that adequate information was not documented in these very brief notes. Several of the individuals seen were adolescents aged 12 -14 years. The treating neurologist included the designation "adult neurology" in his signature stamp. Individuals under the age of 14 years should be followed by pediatric neurology. The records included in the record sample and consult sample contained information related to the provision of neurological services. All of the individuals reviewed were followed at Scott and White Medical Center. Most individuals were seen once a year. Those with intractable or difficult seizure disorder were seen every six months. Individual #248 was evaluated on 8/15/12. The individual was maintained on Depakote monotherapy and was seizure free since 2003. The neurologist did not include any discussion related to the appropriateness of tapering the AED. Individual #175 was seen on 7/12/12 and was noted to have intractable seizures. The recommendation was to consider adding Lyrica and return in six months. It was not clear that any thought was given to more aggressive management for this individual with intractable seizure disorder. For the most part, none of the notes reviewed discussed quality of life measures, side effects of the medications, or any review of the side effects rating tools, such as the MOSES and DISCUS evaluations. Labs were infrequently mentioned and attention to bone health was not addressed. **Additional Discussion** The monitoring team was not informed that a neurology psychiatry clinic was scheduled on the Monday of the compliance review week. This information was provided in passing by the medical department administrative assistant just in time for the monitoring team to attend the afternoon clinic. The monitoring team attended the neurology clinic, which was the designated the neurology-psychiatry clinic. Individual #215 was evaluated by the neurologist. The PCP's participation in the clinic was limited to a discussion with the neurologist at the entrance to the exam room. There was no participation by any other members of the IDT. Moreover, the space designated to conduct this clinic would not have allowed for participation of additional team members due to limited space. During discussions with the neurology consultant, it was clear that	

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		he had no knowledge of the Settlement Agreement or the requirements for integration of neurology and psychiatry via the IDT process. He was not aware of the guiding principles of the IDT and reported that there was no need to have other physicians, such as psychiatrists, participate in the clinic. Additionally, he was not aware of any of the specific requirements related to seizure management as specified in the Health Care Guidelines. For example, the medical director reported that the neurology clinic template from state office was implemented and the template was reviewed with the monitoring team. The neurologist did not use this template for the clinic observed. Upon being informed of issues related to the integration of neurology and psychiatry, he appeared to be willing to engage in the process. **Do Not Resuscitate** The facility submitted a list of individuals who had DNR orders in place. The list included three individuals with Level III DNRs, the dates of DNR implementation, and reasons for the DNRs. Documentation including notes and orders were reviewed for the three individuals. The following is a summary of the information submitted: • Individual #432 had a DNR implemented on 11/16/11 due to guardian request and hospice. The PCP documented in the post hospital note that the individual had the diagnosis of failure to thrive. It was also documented that the individual's status was discussed with the guardian, however, there was no documentation of the IDT discussion or review by an ethics committee. • Individual #120 had a DNR implemented on 12/13/12 due to guardian request. The IPNs did not document the rationale for the DNR, discussion with the IDT, or any other review by an ethics committee. • Individual #185 had a DNR implemented on 9/6/12 due to guardian request. There was no documentation provided of the rationale for the implementation of the DNR. The monitoring team has recommended in previous reviews and continues to recommend that the facility review the list of individuals with DNRs and for every individual ensure that the long term DNRs are clinically justified and fulfill all requirements of state policy.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and	<u>Medical Reviews</u> External medical reviewers, from sister SSLCs, conducted Round 6 of the external reviews in September 2012. State guidelines required that a sample of records be examined for compliance with 30 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were eight essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In	Noncompliance

#	Provision	Assessment of Status	Compliance
	assistance to facilitate the quality of medical care and performance improvement.	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. A total of 25 records were audited. The data provided are summarized in the table below: External Medical Reviews 2011 -2012 % Compliance | | Date of Review | Essential | Non-Essential | | --- | --- | --- | --- | | Round 4 | November 2011 | 82 | 83 | | Round 5 | March 2012 | 94 | 94 | | Round 6 | September 2012 | 83 | 83 | Overall, compliance scores were lower than Round 5 and essentially unchanged from that of Round 4. The areas with the lowest rates of compliance (<70%) included: • Appropriately updated APLs • Inclusion of past medical history, family history and plans of care in the AMAs • Documentation of tobacco use • QDRR response within 15 days by medical providers • Adequate SOAP documentation in the IPNs • Documentation of consults in the IPNs within 5 business days Of the areas identified above, the only area with less than 60% compliance was that of the APLs. The monitoring team did not find significant issues with IPN SOAP documentation in the record sample. As previously mentioned, the findings were very provider specific. For the sample of QDRRs provided in the document request, there were not significant delays in physician response times based on the timeframes designated in facility policy. The monitoring team reviewed the most recent QDRRs completed during the months of May 2012 through August 2012. In addition to the general medical reviews, medical management audits were also completed. Those data are represented below. Disease Management 2012 Round 6 % Compliance | | Constipation | Seizures | UTI | | --- | --- | --- | --- | | Internal Reviews | 70 | 88 | 75 | | External Reviews | 62 | 56 | 56 | A document dated 6/8/12 reported that internal audits were conducted in June 2012 for diabetes, osteoporosis, and seizure disorder. The results for diabetes, osteoporosis, and	

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		seizure disorder were 78%, 74%, and 78%, respectively. Corrective action plans for Round 6 were not submitted at the time of the monitoring team's onsite review. Achieving substantial compliance in this provision will require state office to address several issues with the medical reviews: • The medical management audits will need to address clinical outcomes in addition to processes. • The aggregate data should be used to determine if systemic issues contribute to low compliance scores. When compliance scores are repeatedly low in a particular area, causes for the lack of compliance should be explored. This analysis requires a review of the facility's aggregate longitudinal data. <u>Mortality Management</u> There were six deaths in 2011 and one death in 2012 at the time of the compliance review. There were no deaths since the March 2012 compliance review. The monitoring team met with the medical director, chief nurse executive, and QA nurses to discuss mortality management. The discussion focused on follow-up of implementation of recommendations. It appeared that there was improvement in this area. There appeared to be some improvement in the system and a log was maintained that tracked the status of the recommendations. It was reported that the recommendations from the Quantros organization were not being shared with members of the mortality review committees in a timely manner. In fact, the recommendations received in April 2012 were forwarded to the CNE just three weeks before the compliance review. The monitoring team did not have access to the specific recommendations resulting from the Quantros reviews. The monitoring team highly recommends that the facility implement a process to have a regular discussion of the recommendations related to mortality reviews. This could easily be incorporated into the Medical Review Committee on a quarterly and/or as needed basis since all of the required participants are present for this meeting.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries;	The medical department made no significant progress in this area. The documents given to the monitoring team stated simply that no information was available for this request. The facility self-assessment cited one item - a review of preventive care services. It was reported that the results were based on record audits. In each instance, the results were greater than 90%. During the conduct of this review, the methodology used to arrive at these results was discussed with the medical compliance nurse and the medical director. The medical department should utilize verified <u>hard data</u> to determine compliance ratings. Much of this is collected through clinic tracking.	Noncompliance

#	Provision	Assessment of Status	Compliance
	identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The databases with information related to preventive screenings, osteoporosis, and seizure disorder should be utilized as part of the medical quality program once the medical director has determined how to ensure the collection of accurate data. Moreover, additional indicators should be identified. The state issued guidelines provided important indicators that should be considered for inclusion in the medical quality program. Over a period of two years, the monitoring team has provided continuous feedback to the medical director on the development of a medical quality program. The monitoring team noted that clinical indicators were developed for UTIs, diabetes, osteoporosis, etc., but during interviews the connection between development of these clinical indicators as part of section H and the development of a medical quality program did not appear to register with the medical director and medical compliance nurse. The monitoring team recommends that that significant guidance be offered to MSSLC from state office. Moreover, MSSLC may benefit from examining sister SSLCs that have made some progress in this area. This provision remains in noncompliance.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care 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.	State office issued a series of clinical guidelines and protocols on enteral feeding, aspiration risk reduction, constipation/bowel management, seizure management, urinary tract infections, osteoporosis, diabetes mellitus, and anticoagulation. Several of the state issued clinical guidelines were multidisciplinary and provided guidance to physicians, nurses, and direct care professionals. Realization of the full impact of the guidelines will require participation by all of these disciplines. The facility did not present an overarching strategy for achieving this goal. The medical department developed policies related to management of UTIs, constipation, osteoporosis, and seizure disorder. It did not develop policies related to the other state issued guidelines. The Medical Review Committee minutes did not document that these policies were discussed with the medical staff resulting in a lack of compelling evidence that the medical staff received adequate information on the newly issued policies, procedures, and guidelines. This provision is found to be in noncompliance due to the lack of localization and implementation of all state issued guidelines. The medical director will need to ensure that all state guidelines and protocols are localized and implemented. The medical staff should receive inservicing on policies, procedures, guidelines, and updates in a timely manner. New employees should be required to review this information during the orientation process. Collaboration should occur between medical, nursing, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		residential services to ensure that all disciplines have received training and have successfully implemented the state issued multidisciplinary clinical guidelines.	

Recommendations:

1. The facility must address the current staffing structure to ensure that there is a more even distribution of workload. There should be ongoing efforts to recruit permanent staff and support the current long-term staff (L1).

2. The medical director must address the poor participation by the medical staff in the team process via meeting attendance. This will require an understanding of the causes. Mandating attendance without exploration of the causes is not likely to produce the desired outcome (L1).

3. The various documentation issues must be addressed with the medical staff including the timely completion of QMSs, inclusion of family history in the AMAs, updating of the APLs, and legibility of record entries.

4. The Preventive Care Flow Sheets should be signed and initialed when updated by providers. These documents should be updated at least on a quarterly basis (L1).

5. The medical director should ensure that a thorough 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).

6. The medical director should work with consulting neurologists to ensure that clinic notes contain key data related to seizure management. Recommendations for additional testing and medication management should be specific as should timelines for follow-up appointments (L1).

7. The medical director should have a discussion with the neurologist conducting the onsite clinic regarding the current initiatives at the facility. This discussion should include the requirements of the Health Care Guidelines (L1).

8. The facility should ensure that children are followed by the appropriate neurologist. The current onsite neurologist designated himself specifically as an adult neurologist (L1).

9. The facility must continue to review the list of individuals with DNRs and for every individual ensure that the long term DNRs are clinically justified and fulfill all requirements of state policy (L1).

10. The medical director should draft an algorithm related to the management of recurrent aspiration syndromes providing more detail on the various treatment modalities and diagnostics (L1)

11. State office will need to take several actions in order to achieve substantial compliance with the requirement to complete external facility reviews. Those recommendations are listed in the body of the report (L2).

12. The facility should conduct periodic review of the recommendations generated by mortality reviews. This should be conduced as a formal meeting with the medical director, CNE, QA nurses, medical staff, and representative of the facility director (L2).

13. The medical director should seek guidance from state office in the development of a medical quality program. It may be helpful to review the formats implemented by sister SSLCs that have made progress in this area (L3).

14. The medical director should continue to expand the set of indicators developed. Indicators should be selected from, but not limited to, all of the state issued clinical guidelines as one means of assessing compliance with the guidelines (L3).

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

16. Several action should occur to move towards substantial compliance for Provision L4:
    a. The medical director must ensure that all state issued guidelines are localized and implemented.
    b. The medical director must ensure that medical providers receive timely transfer of information regarding clinical guidelines.
    c. All forms, protocols, and guidelines should include an issue or revision date (L4)

17. The facility director/designee must ensure that all disciplines have received training on the state issued multidisciplinary clinical protocols and have successfully implemented the protocols (L4).

18. The collection, maintenance, and analysis of data for the medical department must be reviewed. It might be helpful to provide some specific training to those who are responsible for data management (L1-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 and action plan – 9/6/12 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 Infection control monitoring tools o Infection Control Surveillance Report 7/1/12 – 9/26/12 o Infection Control Weekly Report 7/1/12 – 9/26/12 o Hand-washing Surveillance Monitoring forms 7/1/12 – 9/26/12 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 9/6/12 MERC meeting minutes o Weekly Skin Reports for all units 8/1/12 – 9/26/12 o Consult Tracking Report 6/1/12 – 9/26/12 o Consult Tracking Log 4/1/12 – 9/26/12 o Campus RN Report 6/1/12 – 9/26/12 o Hospitalizations and ER Visits 8/1/12 – 9/26/12 o Emergent Event Tracking Form o Job description for Skin Integrity/At-Risk Nurse o Job description for RN Case Management Supervisor o List of "low" risk individuals 8/27/12 o QA Nurses project reports completed 3/1/12 – 9/26/12 o Numbers of vacant positions in the Nursing Department o Numbers of nurses in the Nursing Department on FMLA o Curriculum for NEO "Clinical Indicator" course o Curriculum for NEO "Observing and Reporting" course o PETII Meeting Minutes (past six months) o Admission Medical Examination and Admission Comprehensive Nursing Assessment of: • Individual #384, Individual #614, Individual #337, Individual #103 o Records of: • Individual #44, Individual #9, Individual #47, Individual #54, Individual #291, Individual #318, Individual #386, Individual #261, Individual #21, Individual #80, Individual #128, Individual #38, Individual #53, Individual #375, Individual #508, Individual #510, Individual #501, Individual #385, Individual #241, Individual #535, Individual #485, Individual #502, Individual #455, Individual #99, Individual #365, Individual #518 <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, Genie Duke, RN o Nurse Compliance Monitor, Gabby Brewer, RN o Skin Integrity/At-Risk Nurse, Cheryl Trantham, RN o Infection Control Nurse, Phillip Morton, RN o RN Case Manager Supervisor, Mitzi Daniel, RN o Director of CT & D, Deborah Burgess o Dietician, Jennifer Capers, RD o At-risk meeting – 9/26/12 <u>Observations Conducted</u>: o Medication Administration (various units) o Enteral Administration of Medications (various units)

	o Wound/skin care (various units) o Infection Control Committee meeting - 9/24/12 o Skin Integrity Committee meeting – 9/24/12 o RN meeting – 9/25/12 o Nurse Manager meeting – 9/25/12 o ISP meeting – 9/25/12 o MERC meeting – 9/27/12
	Facility Self-Assessment: MSSLC submitted its self-assessment, which was updated on 9/6/12. As recommended by the monitoring team's prior report, the Chief Nurse Executive (CNE), Center Lead for section M, reviewed, 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 the suggestions and recommendations made within the narrative and at the end of the section of the report. As a result, the CNE completely overhauled what was presented the last time and ensured that the self-assessment process resulted in a much more comprehensive, meaningful, and accurate portrayal of the activities and outcomes for each provision item. Although the CNE and the nursing leadership reported that they were concerned that they referenced "too many" activities, which were engaged in to conduct the self-assessment, the monitoring team reassured them that the six to 15 assorted activities referenced under the six provisions of section M were justifiably important and relevant to their evaluation of compliance. During the monitoring team's meeting with the CNE and other members of his leadership team, it was reaffirmed that it will continue to be important for the self-assessment to line up with the topics in the monitoring team's reports. The most important next step for the CNE is to make sure that adequate data are collected to analyze evaluate progress and that identified needs for additional staff training need to provide to ensure implementation of expectations and plans are addressed. Of note, even though more work was needed, the monitoring team wanted to acknowledge the efforts of the CNE to successfully move the self-assessment process forward. The facility rated itself as being in noncompliance with all provisions of section M except M4. The monitoring team agreed that M1, M2, M3, and M5 were in noncompliance, but disagreed with the facility's rating of substantial compliance for M4 and noncompliance for M6.

	Summary of Monitor's Assessment: Since the prior review, MSSLC sustained many of the improvements that they made six months ago and continued to make progress toward meeting many of the provisions of section M. During the review, it was consistently noted and observed that the members of the nursing leadership team and the Quality Assurance Nurse were an experienced, dedicated, and hard-working group of nurses. The CNE reported that since the prior review, the Nursing Department had broadened its scope of monitoring and implemented real-time reviews of nursing assessments and care of individuals with acute changes in their health status. The RN Case Manager Supervisor position was filled with an experienced and knowledgeable nurse who spent the past three and half years doing case management at MSSLC. In addition, there were steps taken to improve not just the presence of documents, such as assessments and health care plans, but the quality of these important tools. Since the prior review, the new Nurse Educator revamped the on-the-job training of nurses and infused the realm of nurse education with renewed energy and enthusiasm. The Nurse Educator worked closely and collaboratively with the RN Case Manager Supervisor and Program Compliance Nurse, and together they continued to demonstrate, by all observations, that they, along with the facility's NOO, Infection Control Nurse, Skin Integrity/At-Risk Nurse, and Nurse Managers, 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, 24 nurses were interviewed, and 26 individuals' records were reviewed. These activities revealed that 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. Notwithstanding these positive and notable findings, there was much work to be done. It was revealed during the review of individual's records that there continued to be 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 continued to be nurses who failed to consistently implement 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 continued to be many positive changes and the potential for many more accomplishments over the next six months.

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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 review, MSSLC reported a number of actions that were taken to achieve substantial compliance with this provision item. At the time of the review, most of the actions were completed, and three actions were in process. Several of the most original and notable actions taken were: • RNs completed and documented focused assessments prior to individuals being seen by their physician in sick call. • RN case managers conducted and documented monthly wellness face-to-face visits to all individuals on their caseload. • Performance coaching sessions were held with nurses who failed to respond appropriately. According to the facility's self-assessment, however, "based on the results of the self-assessment, the provision is not in substantial compliance...[because] there was inadequate data to support findings of substantial compliance, not enough real time data was collected on a regular basis to support documentation of assessments, interventions, and correct use of systems in reporting to readily identify changes in health status." 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, all residential areas were visited, daily observations of nursing care were made, 24 nurses were interviewed, and 26 individuals' records were reviewed. <u>Staffing, Structure, and Supervision</u> Since the prior review, an examination of the staffing data submitted by MSSLC to the monitoring team revealed that over the past six months, there were higher numbers of vacancies, larger turnover rates, and greater numbers of hours of utilization of contract nurses. Of note, at the time of the review, there were 16 vacant nursing positions and two nurses out on FMLA. Although MSSLC's Nursing Department submitted the numbers of its minimum and maximum LVNs per unit for the day and evening shifts, there were no data provided for the night shift, presumably because the campus nurses who worked the night shift were responsible to cover all units. There was also no evidence that the nursing leadership team had completed any analyses of the department's current deployment of staff	Noncompliance

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		members, staff minimums, and staff ratios by residential unit and in accordance with the acuity of the individuals' health needs and risks. Thus, there were no objective data analyses to guide, direct, and support the deployment of nursing staff members across the campus in order to best meet the health needs of the individuals. As a result, the campus nurses, who were responsible for assigning nurses to units, overly relied upon relatively arbitrary minimum and maximum numbers to make their, sometimes very difficult, decisions regarding nursing staff assignments. The review of the staffing data submitted by MSSLC also revealed that despite the significant changes and increased vacancies in the Nursing Department, the facility reported an improvement in the ratio of nursing staff to individuals. It was unclear to the monitoring team how the facility calculated and concluded that, over the past six months, the nursing staff to individual ratio had improved from 1:2.6 to 1:2.2. Reportedly, there was a problem with nurses who came to work late on many days of the month. As of the review, the Nursing Department was contemplating a plan to address this problem and hold nurses accountable to the time and attendance requirements of their positions. The monitoring team encouraged the leadership of the Nursing Department to address and resolve this problem sooner rather than later since it had the potential to significantly undermine the morale of the department's nurses and their progress toward compliance. <u>Recordkeeping and Documentation</u> As noted in the prior review, all individuals' records were organized in a unified form/format. The format of nurses' notes was mostly in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format, which was consistent with the state's standardized protocol. Individuals' notebooks were present on their homes and available to direct caregivers. Notwithstanding these positive findings and the quality assurance checks of the records prior to their submission to the monitoring, there were a number of recordkeeping and documentation problems found in the 26 records selected and submitted by the facility for review, which raised question regarding the state and maintenance of the individuals' records on the units. For example, 10 of the 26 records submitted for review had the following problems: • Three individuals' comprehensive nursing assessments were missing pages or missing entirely. • Two individuals' records failed to have current, annual medical reviews. • Two individuals' records failed to have current, annual ISPs. • Two individuals' records had months of missing pages of IPNs. • One individual's record had no current, annual weight record.	

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		In follow-up to these findings, the monitoring team re-requested the documents and some of the problems noted above were corrected. In addition, as noted in all prior reviews, there continued to be entries that were documented on the margins of the IPNs versus starting a new page, 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, and a significant minority of nurses' names and credentials continued to be illegible. This was an especially problematic documentation issue because it made it difficult, if not impossible, to know when critically important RN assessments were conducted and when/if certain, specific nursing interventions were delivered. Also, despite the variation in the nature of the individuals' afflictions, many nurses continued to document the same oblique references to their planned interventions, such as "Follow-up PRN," and "Will continue to monitor." <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." As noted in the prior review, the Hospital Liaison and the Assistant Hospital Liaison continued to perform their roles and responsibilities with excellence. On a monthly basis, the Hospital Liaisons were visiting and overseeing anywhere from 20 to 50 individuals' hospitalizations and attending and participating in 100% of hospitalized individuals' post-hospitalization ISPAs. Their contributions to the ISP/ISPA processes continued to be very well done, well received, and in accordance with the facility's 1/12/12 nursing protocol regarding hospitalizations, transfers, and discharges. Four of the 26 individuals selected for in-depth review were hospitalized one or more times during the period of 4/1/12 – 9/27/12 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 the Assistant Hospital Liaison throughout his/her	

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		hospitalization. For example, a review of Individual #44's record revealed that she was hospitalized for treatment of a urinary tract infection that was resistant to oral antibiotics. Although Individual #44 was admitted on a Friday afternoon and was slated for transfer to another hospital over the weekend, the Hospital Liaison ensured at least daily contacts with her tertiary care providers for status updates and coordination of care between the hospitals and MSSLC. This was especially significant for Individual #44, who was elderly and became disoriented during her hospitalization. Prior to Individual #44's return to the facility, nurse-to-nurse and doctor-to-doctor discharge reports were obtained from the hospital, which referenced Individual #44's discharge diagnosis, medications, and recommendations for follow-up care. The Hospital Liaisons' communication and collaboration with Individual #44's tertiary care providers and her IST members played a vitally important role in helping to ensure that Individual #44's health and safety risks were reviewed and revised upon her discharge from hospital and arrival to her home unit. During the month prior to the review, when the nurse who was responsible for scheduling and tracking individuals' medical referrals and consultations went out on leave, the Hospital Liaisons were assigned her duties. During an interview with the Hospital Liaisons, it was revealed that there were "tons and tons of referrals that needed to be scheduled and done immediately." Also since the prior review, the Hospital Liaisons were assigned the role of "back-up" to the PNMT RN. Shortly after this assignment, on 8/4/12, the PNMT RN resigned. At this time, in the words of the Hospital Liaison, "it got real deep, real fast," and the expectations for the Hospital Liaisons were unclear. That is, it was not clarified whether or not they were expected to be the "acting PNMT RN" or continue their role of "backup PNMT RN." As of the review, the PNMT RN position remained vacant and the Hospital Liaisons continued to do their level best to meet the needs of the individuals who were referred to the PNMT. To their credit, the Hospital Liaisons never failed to ensure visitation and oversight of all individuals who were hospitalized; they completed the PNMT RN post-hospitalization assessments; and they made sense of, better organized, and implemented the system of requesting and scheduling individuals' medical consultations. However, the number of roles/responsibilities delegated to the Hospital Liaisons, regardless of whether or not they were deemed "temporary," was imbalanced and unreasonable. In addition, it placed individuals at risk of failing to meet their physical, nutritional management, and specialty medical needs. The monitoring team strongly recommended that the CNE intervene to ensure that the Hospital Liaisons were appropriately relieved of excessive demands on their time and expertise and received clarification of the expectations of their role as backup PNMT RN.	

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		Wound/Skin Integrity 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." A review of the facility's 9/6/12 action plan failed to reveal that any specific, targeted actions were taken to address the problems identified in this area during the prior review. For example, there was no evidence that, as recommended, the new Skin Integrity/At-Risk Nurse actively sought out and received adequate support, guidance, and direction on how to implement the expectations and duties of her job as a member of the nursing administration team. Thus, the problems identified in the prior report persisted. For example, in response to the monitoring team's request for the Skin Integrity/At-Risk Nurse's job description, her performance plan summary was submitted. This provided only general information on the broad job functions of the position. For example, the Skin/Integrity/At-Risk Nurse: • Monitors wounds as needed and at risk issues of all persons served, • Intervenes as necessary to facilitate wound healing, • Monitors RN case managers' documentation of wound care and at risk persons for completeness of nursing care plans, • Performs physical assessments, in accordance with training and facility protocols, and • Collects and organizes wound care data and chairs the Wound Care Committee. Thus, it was not surprising the Skin Integrity/At-Risk Nurse continued to be unable to explain how she specifically structured, organized, planned, and carried out particular duties to ensure that individuals with alteration in skin integrity would be promptly identified and benefit from skilled wound care, in accordance with a specific schedule of activities from the time an alteration in skin integrity was identified to its resolution. Rather, the Skin Integrity/At-Risk Nurse replied to the questions from the monitoring team with only very vague references to her duties as the Skin Integrity/At-Risk Nurse at MSSLC. For example, she reported that she was "doing a lot of skin care," "checking [individuals] that were important to check," "trying my best to look at all [individuals] if they were not better," and "check on [alteration in skin integrity] until I feel it's better." It remained unclear to the monitoring team why the Skin Integrity/At-Risk Nurse had	

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		failed to utilize MSSLC's "Guidelines of Prevention and Treatment of Altered Skin Integrity (NS 58)" to help her manage and implement the facility's program for "preventing and addressing alterations in skin integrity for individuals at MSSLC through proven established techniques..." The frailties of the skin integrity program at MSSLC were apparent during the review of the sample individuals' records. At least seven of the 26 sample individuals' records selected for in-depth review had one or more problems with alteration in skin integrity. None of the six individuals' records revealed that their skin issues were identified and addressed, in accordance with standards of practice. For example: • On 8/4/12, Individual #518's direct care staff member noticed an open area to Individual #518's inner buttocks. There was no RN assessment of Individual #518's alteration in skin integrity until 8/6/12; Individual #518's physician was not notified until 8/15/12; Individual #518 was not seen or evaluated by the Skin Integrity/At-Risk Nurse until 8/28/12; and as of the monitoring review, on 9/26/12, Individual #518 was waiting to undergo a general surgery consultation of her still open wound that was draining brown-yellow pus. • On 8/16/12, Individual #291 suffered a skin tear across her right ankle. Over the next three weeks, Individual #291's physician prescribed treatment and periodically checked the wound for signs of infection, healing, etc. Of note, Individual #291's physician noted that her wound was "healing very slowly." Although it took three weeks for Individual #291's wound to heal, there was no evidence that the Skin Integrity/At-Risk Nurse was involved in the assessment, treatment, or monitoring of Individual #291's alteration in skin integrity. Problems with the implementation of the facility's skin integrity program were also revealed during the monitoring team's observations of the Skin Integrity/At-Risk Nurse's wound care/treatment rounds. For example: • No privacy was afforded to the individuals' during their treatments. Thus, individuals' private areas were exposed to their roommates and to various staff members who were not assisting with the treatment. • Skin cleansing disposable wipes were removed from the manufacturer's package and carried openly on top of the wound care/treatment cart. • Creams/ointments from unlabeled tubes/bottles, which were used for more than one individual, were dispensed into unlabeled medication cups. Problems with the facility's skin integrity program were also revealed during the monitoring team's review of the minutes of the Skin Integrity Committee meetings, which were submitted, and during the team's attendance at the 9/24/12 Skin Integrity Committee meeting. For example:	

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		• Data were presented, but there was little, if any, discussion of possible patterns and trends in skin integrity issues, analyses of data for patterns, and recommendations for preventative measures and management. Rather, the meeting, and the review of the meeting minutes, was limited to some discussions of specific individuals' skin problems. • Although a glimpse of a possible pattern and/or trend of decubitus ulcers was presented to the committee vis a vis line graph of decubitus ulcers per month, the attempt to identify a trend in this untoward outcome fell short of informing the committee of the exact nature of the problem at MSSLC because no distinctions were made in the data between incidence and prevalence of decubitus ulcers across the facility. Thus, there was no cogent explanation for the decreasing trend line depicted by the graph. • Planned actions were often confused with outcomes and vice versa. • The basis for the Skin Integrity/At-Risk Nurse's recommendations for the treatment of wounds, especially unstable and non-healing wounds, was unclear. For example, in response to Individual #518's physician's order for a wound care consultation, the Skin Integrity/At-Risk Nurse recommended a combination of calcium alginate (Sorbsan) and Duoderm to treat her wound. The facility's wound-certified physical therapist agreed with the recommendation and stipulated that the dressing should stay on for 24 hours, but if that were not possible, an island dressing could be used. Thus, Individual #518's physician ordered, "Calcium alginate and thin Duoderm to gluteal cleft wound Q AM and PRN soiling until healed." So, on an almost daily basis, Individual #518's wound was cleansed and calcium alginate and Duoderm dressings were applied, one on top of the other. Of note, according to the literature, calcium alginate and Duoderm were two different types of dressings that were used to treat different types of wounds with different types and amounts of exudate. They were also recommended different timeframes for dressing changes, and they were not recommended to be placed on top of each other. It was the opinion of the monitoring team that much of the responsibility for the continued failure of the facility to implement an effective skin integrity program fell squarely on the shoulders of the CNE who, six months ago, reported that it was his responsibility to supervise and manage this very important aspect of the delivery of health and nursing care supports and services to the individuals who reside at MSSLC. During the onsite review, the Nursing Department quickly fashioned and submitted a corrective action plan to the monitoring team, however, an examination of this plan revealed that it was insufficient to address and correct the numerous problems referenced above.	

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		Infection Control Since the prior review, the facility reported that its infection prevention and control program continued to provide competency-based training in infection control practices and procedures for all new employees and monitor all active and new employees compliance with TB testing. In addition, it was reported that the Infection Control Committee continued to meet each month, identify problems, and make recommendations for changes to improve the prevention and control of the spread of contagions. Since the prior review, another new Infection Control Nurse was appointed to the position. Although the new Infection Control Nurse had been on the job only two short weeks prior to the monitoring review, he was already looking for ways to improve the collection, recording, analysis, and presentation of the facility's infection data. For example, the Infection Control Nurse was planning to improve compliance with basic infection control interventions, like handwashing, conducting regular rounds on all units while focusing on Martin, and overseeing compliance with routine immunizations and special vaccinations. As noted in prior reports, the NOO continued her extensive involvement in the growth and development of the facility's infection prevention and management program. Over the coming weeks and months, it will be critically important for the new Infection Control Nurse to be present and available on the units, bringing the facility's infection prevention and control program from the office and the meeting rooms to the front lines of nursing care. The monitoring team's in-depth review of 26 sample individuals' records revealed numerous opportunities for the Infection Control Nurse to positively affect the delivery of individuals' health and nursing care. For example, on 8/22/12, Individual #455 developed a high fever and was diagnosed with streptococcal pharyngitis, a contagious disease caused by infection with streptococcal bacteria. Although the individual's infection was documented on the facility's Weekly Infection Report, there was no evidence that the acting Infection Control Nurse followed up on this report and brought his/her expertise to bear on the unit. Similarly, on 8/3/12 and 8/27/12, Individual #508 suffered human bite wounds that broke his skin. On both occasions, Individual #508 was prescribed antibiotic therapy. Only one of the two human bite wounds was reported to the Infection Control Nurse, and neither prompted the acting Infection Control Nurse to conduct an investigation of the individuals' disease and immunization/vaccination histories to help inform their IDT members regarding their health risks related to contracting and transmitting infectious diseases. 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	

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		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 the health risks associated with the West Nile Virus, strategies to improve employees compliance with flu vaccination, 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 template and outline for conducting the committee meetings, but was eager to add some new twists to the conduct of the meetings. Since the prior monitoring review, in the absence of an Infection Control Nurse, the NOO 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 infection control and prevention. <u>Emergency Response</u> A review of the state of medical emergency equipment and response at MSSLC revealed several improvements upon the problems noted during the prior reviews. For example, medical emergency equipment, which was regularly checked, was available and accessible to staff members. In addition, there was evidence that nurses responded to over half of the drills, and several drills included participants from the habilitation and psychology departments. Another notable improvement found during the monitoring team's review of the Emergency Drill Checklists and the Emergency Medical Drill database was timely follow-up action taken to address the problems identified during the drills. For example: • On 8/22/12, the Emergency Drill Checklist indicated that an LVN did not seem to know the emergency procedures and "needed to come back to CPR training." The day after the drill, the LVN's Nurse Manager personally and immediately conducted follow-up to this report, addressed the issue, and resolved the concern. • On 7/21/12, the Emergency Drill Checklist indicated that one of the staff members needed to attend a CPR refresher course. Within 72 hours of the report, the staff member attended the CPR refresher course. Notwithstanding these improvements, since the prior review, there was no evidence that the facility's Emergent Events Tracking Form was being used to document care during real-life, real-time medical emergencies at MSSLC. This form was developed in response to clinical professionals' requests and their opinions that the learning that comes from a retrospective review of actual events was invaluable. Thus, it was disappointing that when the monitoring team requested to review these forms, there were none. A review of one of the 26 sample records reviewed revealed that MSSLC missed an opportunity to	

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		learn from tracking one of these same events. On 6/23/12, Individual #9 punched his right fist through the glass window in his bedroom. He severely lacerated his right wrist and arm, transected nerves and tendons, and lost over a liter of blood. From the moment the emergency was discovered to the time when Individual #9 left the facility, all interventions were critical to saving Individual #9's life and limb. Undoubtedly, if the Emergent Event Tracking Form had been completed, it would have been a very useful training tool. <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 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 26 sample individuals reviewed, there was evidence that their physicians consistently responded to nurses' notifications of significant changes in their health status and needs and/or when the individuals needed to be seen by their doctor. However, as noted in prior reviews, it was the direct care staff members who continued to be the first responders and reporters of health care problems and concerns to the LVNs. Thus, there continued to be a heavy reliance upon the direct care staff members to readily identify problems, and on the LVNs to promptly respond to the direct care staff member's report, review the individual and situation, and report their findings to RNs for assessment, monitoring, and referral to the physician. A review of 26 sample individuals' showed that 19% of the records reviewed revealed that nurses usually properly identified and completed follow-up to significant changes in individuals' health status. For example: • Individual #261 was a 17-year-old adolescent who had few chronic health problems, but frequently suffered acute changes in his health status, such as contusions, broken nose, nausea and vomiting, weight loss, upper respiratory infection, and second degree burns. Nonetheless, Individual #261's nurses' identified, addressed, and monitored all of his health events until they were resolved. • Individual #54 was a 60-year-old man with several ongoing health needs, including hypertension, kidney disease, and obesity. In addition, his inappropriate sexual behaviors increased his risk of developing acute and	

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		chronic health problems. Over the past six months, a review of his record revealed that his nurses identified, addressed, and monitored his health problems as they emerged, and when his behaviors increased his risk of developing health problems, his RN case manager provided him with important health information and education. Notwithstanding these positive findings, across 81% of the records reviewed there was a pattern of nurses' failure to ensure proper identification and complete follow-up to significant changes in individuals' health status. The following examples represented the seriousness of this problem at MSSLC. • On 7/30/12, at 12:00 pm, Individual #535's direct care staff reported to his LVN that he stated that he did not feel well and was tired and sleepy. Individual #535's nurse documented a brief assessment and reportedly placed on follow-up for further monitoring. At 1:30 pm, Individual #535's LVN notified the RN on duty that Individual #535 was "acting different." Although Individual #535's RN's assessment revealed that he was complaining of chest pain, his pulse was elevated (> 100 bpm), and he requested a "pain pill," there was no evidence that he received any medication for pain and no evidence of follow-up assessment or monitoring of his complaints to make certain that his complaints were indeed related to him "being sore from working out" and not the warning signs/symptoms of a heart attack. • On 8/10/12, at 11:40 pm, Individual #38's direct care staff member reported to his LVN that he had vomited. The LVN obtained an incomplete set of vital signs and noted that he/she "will place on follow-up for further vomiting episodes and will refer to RN/MD when indicated." At 3:15 am, Individual #38 vomited again, a large amount, and it was noted that the RN was advised. It was not until two hours later that Individual #38 received an assessment by the RN. At this time, the RN failed to implement the proper protocol, that is, Individual #38's enteral feed was not stopped, which placed him at risk of aspiration, and his physician was not notified. Hours later, Individual #38 had three more episodes of vomiting. Finally, Individual #38's physician was notified, orders were given to hold his enteral feeding, and he was sent for an x-ray. • Over the past six months, Individual #508 suffered multiple head injuries, many of them self-inflicted. His head injuries ranged from mild to moderate, however, regardless of the severity, most of his head injuries were not assessed and monitored in accordance with the state's head injury protocol, which clearly specified the minimum frequencies for neurological assessments and monitoring. Of note, there was no evidence that Individual #508 was evaluated or monitored for possible second injury syndrome (SIS) and/or the effect of repetitive head injuries, similar to what occurs for individuals who participate in sports that involve head impact.	

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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 and the Post-Hospital/ER/LTAC 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 quarterly/annual 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. Of note, since the prior monitoring review, 29 of the MSSLC RNs completed the RN physical assessment course, which continued to help improve their knowledge and training in identifying and evaluating variance in health status indicators. On 10/22/12, an additional 32 RNs were scheduled to attend the physical assessment course. Also, MSSLC had fully implemented the state's protocols for nurses to help them in their performance of assessment, documentation, and reporting to physicians and other clinical professionals their findings related to several, frequently occurring health problems, such as vomiting, infection, constipation, seizures, etc. In addition, since the prior review, the Nursing Department implemented a procedure whereby all Registered Nurse Case Managers were required to complete a wellness visit monthly on all individuals and document their face-to-face visit in the Integrated Progress Notes. This appeared to be a strategy to address some, but not all, of the problems associated with the facility's nurses' practice of documentation by exception, which continued to have significant problems that set back many of the CNE's and nursing leadership team's efforts to obtain substantial compliance with the provisions of section M. It should also be noted that in mid-May 2012, the Nursing Department filled the RN Case Management Supervisor position with an RN who had many years of nursing experience outside of MSSLC and 3.5 years doing nurse case management at MSSLC. During the monitoring team's interview with the RN CM Supervisor, it was learned that several planned initiatives were already underway, such as regular meetings with RN case managers, frequent reviews of samples of the RN case managers' work, and, based upon the outcomes of the reviews, implementation of targeted training sessions and increased oversight to improve performance and achieve compliance with the provisions of the settlement agreement.	Noncompliance

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		The presentation book for section M showed evidence of numerous, ongoing activities to address the delinquencies in nursing assessments. Over the past six months, the Program Compliance Nurse and the RN case managers spent many hours working on the annual and quarterly comprehensive nursing assessments and the discharge summaries to improve their timeliness and content. According to the facility's self-assessment, over the past several months, between 89% and 100% of the annual and quarterly nursing assessments and 80% of the discharge summaries were completed in a timely manner. Although the facility's ongoing reviews of the content of nursing assessments revealed that improvements were made, the facility concluded that they were not in substantial compliance because there was "inadequate historical data to support substantial compliance in that the review of four annual/quarterly comprehensive [nursing] assessments [showed] an identified need for further training and documented compliance with training to support findings of compliance." The monitoring team agreed with the facility's rating of noncompliance. It should be noted, however, that the review of the 26 sample individuals' records revealed pockets of improvements in the content and quality of some of the comprehensive nursing assessments. For example, Individual #54's annual comprehensive nursing assessment was completed six days prior to his annual IDT meeting. However, during the six days prior to Individual #54's annual planning meeting, several significant health events occurred. Since Individual #54's RN case manager was well informed of his health needs and risks, he/she completed an addendum to the assessment to ensure that Individual #54's IDT was fully informed of his health status and changes that occurred over the past year. There were noticeable improvements in some of the nurses' assessments of the individuals' responses to, and the effectiveness of, their medication regimens. For example, Individual #291's comprehensive nursing assessments referenced specific information to support the nurse's conclusion of "good" response to her medication(s). In regard to Individual #291's good response to her medication for constipation, her nurse noted that she had not required the use of PRN laxatives during the review period; and in regard to her good response to her calcium and vitamin D supplements, her nurse noted that her blood test results showed normal levels of calcium and optimum levels of vitamin D. The review of 21 sample individuals' records revealed that nursing assessments were indeed timely, however, with respect to content, they continued to fail to meet the provisions of the Settlement Agreement and Health Care Guidelines. As a result, a rating of noncompliance was given to this provision item.	

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		Across the sample of individuals reviewed, nursing assessments continued to have many of the deficiencies described below. Of note, most of these deficient practices were also found during all prior reviews: • Current active problem lists were incomplete and not up-to-date. • A number of nursing assessments continued to fail to show meaningful reviews of individuals' response to and effectiveness of all of their medications and treatments. • Individuals' significant histories of chronic and acute conditions, including, but not limited to, respiratory illnesses and infections, heart disease, skin breakdown, and medication side effects were not completely identified and evaluated. • Nursing assessments that indicated that individuals had pain management problems failed to reference complete evaluations of the location, intensity, onset, duration, quality, etc. of the individuals' pain, and what alleviated and/or aggravated their pain. • Lists of nursing problems/diagnoses were incomplete and, occasionally, referenced problems/diagnoses that were not identified or revealed during the comprehensive assessment or elsewhere in the individuals' records. In addition, it was not uncommon to find lists of nursing problems/diagnoses carried over from one nursing assessment to the next regardless of changes in the individuals' health problems, needs, and risks. • Nursing summaries, especially the annual reviews, continued to need improvement. In general, they continued to be difficult to read and understand the main points and almost always left the reader wondering how all of the various health events, treatments, interventions, risk reduction activities, etc. impacted the individuals' functioning and participation in activities of daily living and the quality of their lives. • Post-Hospitalization/ER/LTAC assessments continued to have sections that were inexplicably left blank, such as whether and what information was communicated to the individuals' clinical professionals and other IDT members, what health care plans were developed/needed to be developed to meet the individuals' needs upon discharge from the tertiary care provider, etc. • The five admission nursing assessments that were reviewed were in dire need of improvement. For example, one or more of the nursing assessments failed to document a complete physical assessment, conclude with any nursing diagnoses, correlate assessment findings with developmental milestone (for a 12-year-old child), and/or assemble even minimal, basic health information for purposes of a cogent summary. In addition, two of the five admission assessments were not completed until several weeks to over one month after admission. • The five discharge nursing summaries that were reviewed were also in need of	

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		improvement. Although they all started out with the same form/format, some summaries included and referenced the individuals' health care plans and others did not. In addition, some summaries provided a short, and others provided a lengthy, rundown of the individuals' health status and risks. However, the failure to describe the individuals' participation in their health care and explain their progress/lack of progress toward the achievement of their desire health was consistent across all summaries reviewed. The following examples from this sample indicated the seriousness of this problem at MSSLC. • Individual #261 was a 17-year-old adolescent boy who was diagnosed with dysplastic nevi on his penis. According to Individual #261's physician's 4/3/12 annual medical review, he was last checked on 4/6/11 by a dermatologist, "[thus] will request status of appointment for 2012." A review of the medical appointment/consultation- tracking log revealed that Individual #261 had dermatology appointments scheduled on 6/21/12 and 8/24/12, however, he failed to attend these appointments. Although Individual #261's RN case manager noted Individual #261's missed appointments during his/her quarterly comprehensive nursing assessment, as of 9/27/12, there was no evidence of follow-up to ensure that the individual received timely and appropriate care. • Individual #485 was a 49-year-old man who was overweight and diagnosed with hypertension, hyperlipidemia, vision impairment, and degenerative joint disease of his right ankle. Over the past six months, Individual #485's dietician expressed concern over his physical inactivity and frequent substitution of regular meals with his purchases of unhealthy foodstuffs. Notwithstanding Individual #485's health problems and his dietician's concerns, the meal monitoring portion of his nursing assessment only indicated that he "ate 100%, no difficulty chewing or swallowing," and failed to reference whether or not he made healthy versus unhealthy food choices, controlled portions, limited sweets, etc., as recommended by his clinical professionals and referenced in his health care plans. In addition, Individual #485's nursing assessment failed to reference his vision impairment and, under the heading of history of musculoskeletal disorders, it failed to reference his degenerative joint disease. • Since Individual #318's recent admission to MSSLC, he had several specialty consultations/evaluations and had surgical extraction of six teeth. Although Individual #318's quarterly drug regimen review indicated that he needed a health care plan for xerosis, his ophthalmologist diagnosed him with a vision impairment and recommended prescription lenses, his dentist noted that his oral hygiene was only fair, and he was underweight and failed to gain adequate weight since his admission, his nursing assessment failed to reference these	

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		problems. Thus, Individual #318 failed to have an adequate health care plan in place to meet his health needs and reduce his health risks.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	According to the Health Care Guidelines and DADS Nursing Services Policy and Procedures, based upon an assessment, a written nursing care plan should be completed, reviewed by the RN on a quarterly basis and as needed, and updated as to ensure that the plan addressed the current health needs of the individual at all times. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of interventions. In addition, the state's 12/30/11 guidelines for the routine responsibilities of the RN case managers reaffirmed that, with regarding to planning, they must actively participate in 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 managers 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 Officer 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 self-assessment, a number of activities went into their review of their status toward compliance. They conducted a number of reviews of plans for their presence and quality, and they reviewed IPNs for references to the development and implementation of plans and training of direct care staff members to carry out their delegated health care duties. The facility also reviewed a sample of care plans related to health risks, which were rated as "high" for the individual, and found that most of these plans were present in the individual's active record and notebook. Despite these positive findings, the facility determined that they were not in substantial compliance because they recognized that "increased monitoring and training was needed to improve the overall quality of the care plans [and] there was not enough evidence of documentation of demonstrated progress to support findings of substantial compliance." The monitoring team agreed with the facility's rating of noncompliance and also agreed that, although the presence of plans in active records and notebooks had significantly improved over the past six months, there continued to be a number of problems ensuring that the plans accurately portrayed the health status and needs of the individuals,	Noncompliance

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		referenced adequate interventions to achieve the desired health goals, and showed evidence of reviews and revisions, as appropriate. Over the next six months, with the expected roll out of the state's integrated health care planning process, this aspect of the delivery of nursing supports and services will significantly change, expectantly, for the better. Currently, the monitoring review of 26 individuals' records revealed that, although many more individuals had many more plans developed to address their health care needs, including their needs associated with their health risks, than what was the case six months ago, there continued to be a pattern of failure to ensure that plans were adequate, appropriate, reviewed, revised, and resolved, as appropriate. Some general comments regarding the 26 sample individuals' care plans are below. Of note, all of the findings were consistent with the findings from the prior reviews. • The generic, stock, mini-plans, some of which were reviewed at least quarterly, many of which were not, continued to be the pattern of health care planning at MSSLC. • Almost identical HMPs were used to address health problems regardless of the individual's co-morbid conditions and/or the precursors, nature, scope, and intensity of the problem and/or their level of and ability to participate in their own health care. • At least two of the 26 individuals had physician's orders to develop an exercise program with the assistance of the habilitation department. There was no evidence of an exercise program or plan in either of these two individuals' records. • Less than 20% of the 26 individuals records contained plans that addressed all of the current health needs of the individuals at all times. • There continued to be examples of when the implementation of care plan interventions was not appropriate to meet the individuals' needs. For example, Individual #365's HMP referenced a goal that was developed for Individual #355. Individual #38, who received nothing by mouth and all nutrition, fluids, and medications via enteral tube, had a HCP developed to address his risk of aspiration and respiratory compromise, which stated that a criteria for treatment per nursing protocol was for "known ingestion of unsuitable foods, such as numerous candy bars, 10 green apples, eating an object that is not edible." Clearly, this HMP was not developed with Individual #38's health needs and risks in mind, but since its placement in his record, at least twice an RN signed off as having reviewed and approved his HMP.	

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		More examples of problems in the HMPs and ACPs of specific individuals are below: • Individual #241 was a 56-year-old man who was diagnosed with multiple chronic and acute health problems, such as GERD, hypertension, COPD, renal insufficiency, insomnia, vision impairment, nicotine addiction, and, recently syncope with a pending cardiac work-up. Notwithstanding his many health needs, he failed to have HMPs to address his GERD, oral hygiene deficit, and renal insufficiency, and failed to have an ACP developed to address his episode of chest pain and syncope. • Individual #502 was a 62-year-old man who suffered for weeks with open wounds related to stasis dermatitis with pruritus. Although his treatment for these wounds required specialized treatment, including visits to the Wound Care Center in Waco, there was no HMP in place to address this significant health problem. • Individual #54 was a 60-year-old man who had several current active health problems, including hypertension, chronic kidney disease stage III, chronic interstitial nephritis, hyperlipidemia, anemia, vitamin D deficiency, osteopenia, onychomycosis, obesity, and periodontal disease. In addition, Individual #54 had challenging behaviors, including high-risk sexual activity. Notwithstanding his high health risks, such as his risk of STDs, which were closely related to his inappropriate behaviors and recent incident of sexual contact with a male peer, these risks were not identified with a nursing diagnosis. Thus, there was no HMP developed to address this significant health risk.	
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. This provision item clearly ties assessment and reporting protocols to outcomes, and 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, expected outcomes. Expected outcomes will depend on the individual and his/her situation, and they may include maintaining or attaining health or achieving end of life goals. The facility's self-assessment indicated that, since the prior monitoring review, MSSLC continued to work hard toward achieving substantial compliance with this provision item. The Nursing Department's Program Compliance Nurse broadened the scope of her monitoring reviews to include real-time, on-the-job monitoring, with a special emphasis and focus on ensuring nurses' implementation of the state's assessment and reporting protocols. A review of the documents submitted by the facility and the presentation book for section M revealed that, since the prior review, hundreds of monitoring tools	Noncompliance

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		were completed, monthly continuing education and training sessions were held, weekly, unit-based focus meeting minutes documented follow-up to the findings of the monitoring reviews, and every nursing leadership meeting referenced some discussions of the progress toward and barriers to compliance. The Nursing Department's presentation at the facility's 9/26/12 Performance Evaluation Team (PET) meeting indicated that, over the past six months, the compliance scores associated with nurses' implementation of the assessment and reporting protocols related to acute illness, injury, emergency room visits, hospitalizations, skin integrity, seizure management, prevention, infection control, respiratory distress, documentation, as measured by the facility, consistently scored 80% and higher. In addition, the Nursing Department postulated that the improved compliance scores in these areas were associated with the facility's overall decline in reported numbers of hospitalizations, ER visits, and frequency of some infections and alterations in skin integrity. Notwithstanding these positive findings, the Nursing Department concluded their 9/26/12 presentation with the caveat, "Protocol card assessments are not fully completed. Use of the protocol card checklist, raising awareness, and timely corrective action and teaching shoulder-to-shoulder with the nurses will assist us in achieving compliance with the use of protocol cards. Protocol follow-ups are being done, but complete assessments are required use the protocol card criteria." Nonetheless, the facility's self-assessment concluded that, based upon their findings, this provision was in substantial compliance because it showed, "All nurses currently working and new hires are trained and competent in all areas. They have protocol card guides, and they are using the in their practice to aide in documentation and reporting. [The self-assessment] revealed sufficient numbers of corrective actions taken in all areas to improve outcomes. Outcomes in critical areas of concern show a downward trend in all areas this past fiscal year." The monitoring team agreed that MSSLC continued to have systems and processes in place to identify and improve nursing care, and notable improvements in some nurses' implementation and documentation of assessment and reporting protocols were accomplished. But, the monitoring team was not in agreement with the facility's self-rating of substantial compliance because the review of the 26 sample individuals, 20 of whom were selected by the facility, continued to reveal a pattern of problems in the implementation of the nursing assessment and reporting protocols to protect individuals from harm, promote their health and safety, improve nursing practice, and ensure consistent application of the nursing process to reliably meet the health needs and risks of the individuals served at MSSLC.	

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		Examples of the specific findings are presented below: • The protocols for seizure, temperature elevation, and use of antibiotic(s) were more likely to be consistently implemented than all of the other protocols. • Over the past six months, one-fourth of the sample individuals suffered from one to many mild to moderate head injuries. Only one individual's head injury was assessed and monitored, in accordance with the head injury protocol. The most frequent problems identified during the review of individuals with head injuries were that they were not properly and consistently assessed during the first four hours post-injury, and they were frequently not assessed during the night. • Individuals who complained of constipation and/or abdominal pain and/or distention failed to have complete assessments and follow-up to abnormal findings. • Twenty percent of the sample individuals suffered one or more urinary tract infections. Notably, many individuals' records failed to reveal evidence of nurses' assessment and monitoring of the color, clarity, and odor of their urine and/or the frequency and amount of their urination. • The assessment and reporting protocols were applied rote for individuals despite the dramatic differences in their health needs and risks. o For example, although there were obvious differences in the health needs and risks of Individual #261, who was a 17-year-old adolescent boy, mildly intellectually disabled, verbal, and without an enteral feeding tube, and Individual #38, who was a 67-year-old man, profoundly intellectually disabled, nonverbal, and with an enteral feeding tube, their episodes of vomiting were similarly assessed and monitored. o The same was true of nurses' implementation of the pretreatment and post-sedation monitoring protocol. The mildly intellectually disabled, verbal individuals who underwent tooth extraction appeared to require somewhat different applications of the pretreatment post-sedation monitoring protocol than the severely intellectually disabled, nonverbal individuals who underwent colonoscopies. These individuals and their situations, risk factors, abilities/disabilities clearly called for nurses to assess and monitor them post-procedure, but they most certainly appeared to require different interventions to meet their needs and ensure their health and safety. There were three points for MSSLC's Nursing Department to consider as they continue to work toward substantial compliance with this provision item: • The state's assessment and reporting protocols were developed for use as a tool	

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		and not a substitute for clinical judgment or critical thinking. • The state's assessment and reporting protocols were not developed to supersede physician's orders or take the place of physician notifications. • The state's assessment and reporting protocols were not designed for rote application across individuals who may have similar problems, but have very different needs and abilities. Since the prior review, the Nursing Department brought a new Nurse Educator on board. During the facility's 9/24/12 opening presentation, the CNE reported that the new Nurse Educator had revamped nurses' on-the-job training, and there continued to be an expansion of new employees' training on clinical indicators, health risks, and the implementation of risk action plans. During the monitoring team's interview with the Nurse Educator, it was reported that since the prior review, training areas, a classroom, and a storage area for education materials were established. Observations of these areas revealed that they were impressively organized, equipped, and ready for the implementation of the state's new training initiatives. As of the review, 29 MSSLC RNs attended and completed 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, and 32 more RNs were scheduled to attend the physical assessment training course on 10/11/12. The training sessions provided to the RNs was welcomed, well attended, and appeared to benefit the nurses and the individuals they served. One of the areas that the Nurse Educator must address over the six months is the Nursing Department's lack of evidence, vis a vis employee paper files or electronic records, of nurses' competency and testing and the original completed skills check list for the nurses' current positions, as required by the state's 8/10/10 Nurse Competency Based Training Curriculum policy and procedure. As described in the facility's self-assessment, since the prior monitoring review, there were two actions that were taken by the Nursing Department that involved collaboration with the Quality Assurance Nurses. First, the Nursing Department completed its implementation of the recommendations from the 8/11 – 2/12 QA Death Reviews for Nursing recommendations, and second, the Nursing Department participated in monthly meeting with the QA Nurses "to improve quality of care." Of note, there were no deaths that occurred during the six month period of 2/12 – 9/12. That being said, as noted during the prior review, the QA Nurses involvement and participation in the Nursing Departments ongoing quality assurance activities continued to be less than what it was during prior visits and continued to be much more difficult to discern.	

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		For example, since March 2012, in response to questions from MSSLC administration and in follow-up to clinical services' reports, the QA Nurses conducted reviews of four aspects of the facility's delivery of health and medical supports and services – hospitalizations of a sample of individuals, frequency of replacement of enteral feeding tubes, use of controlled substances for treatment of pain, and enteral intake of individuals receiving near continuous feeding. A review of these reports revealed that they were complete, comprehensive, and appropriately critical of sub-standard care. Each and every review found significant and serious problems with nurses' implementation of various assessment and reporting protocols, such as vital signs, hypothermia, pica, enteral nutrition, acute illness and injury, hospitalization, and documentation. Although the QA Department requested that the Nursing Department develop corrective action plans to address the problems identified, the monitoring team encouraged the QA Nurses to combine their efforts with those of nursing leadership, the Program Compliance Nurse, and the RN Case Management Supervisor to come up with plans and strategies that may not only correct the problem at hand, but reduce the likelihood that the same or similar problems will reoccur. This was especially relevant to the findings of the QA Nurses' current reviews, which shared strikingly similar findings to those identified during the reviews of two individuals who died over the past two years.	
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 almost two years of its implementation of the state approved, and frequently revised, health risk assessment and risk action plan development process as part of the ISP process. According to the facility's self-assessment, since the prior monitoring review, the Nursing Department's Program Compliance Nurse completed dozens of monitoring tools as part of the facility's evaluation of its compliance with this provision item. The results of the monitoring tools revealed that risk assessments and plans were usually filed in individuals' active records, but not necessarily in the individuals' notebooks. Of note, the results of the monitoring also revealed improvement in the facility's conduct of timely risk assessment and planning meetings after individuals' discharge from the hospital. A portion of the credit for this improvement was probably owed to the Hospital Liaisons, who attended and participated in these meetings 100% of the time. However, the facility's self-assessment concluded, "We find the provision M5 not in substantial compliance. There is a lack of data showing integration of the team in development of action plans and the data showing the implementation of action plans is unsatisfactory. There is also a lack of completion and implementation of care plans for individuals that have high risks identified. There was also not enough monitoring for the presence of clinical indicators contained within the action plans developed."	Noncompliance

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		The monitoring team agreed with the facility's self-rating of noncompliance. However, as noted during all prior reviews, 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. As noted in the prior report, on 3/15/12 the Nursing Department assigned "at-risk" duties to the new Skin Integrity Nurse. Although this role/responsibility was presumably in place for over six months, during the monitoring team's interview with the Skin Integrity/At Risk Nurse, it was revealed that she was not any more 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 than she was six months ago. Despite the Skin Integrity/At-Risk Nurse's attendance at 35-plus ISP/ISPA meetings over the past six months, she was not authorized to direct or lead the IDTs' health risk reviews and discussions of risk action plans, and she was not always provided with advanced notice of the meetings. Thus, she was not consistently well-prepared, she was not deemed or acknowledged to be the facility's expert in this area, she did not view herself as a "vital member" of the team, and she had no outline of the expectations of this position as part of her job description. Rather, the Skin Integrity/At-Risk Nurse described her role as a "support, not a leader" whose "vote doesn't count." During the conduct of the review, the monitoring team attended one ISP meeting, which was held on behalf of Individual #151. The QDDP who chaired the meeting continued to need additional training and support to ensure that the meeting moved along in accordance with the ISP guidelines, and that participants remained focused and engaged in the process. Of note, the QDDP's conduct over the course of the meeting changed from a somewhat passive moderator to a more directive leader of the discussion, which was appreciated by the monitoring team and some members of the individual's IDT. The meeting started off with a list of Individual #151's strengths, but very quickly moved to a lengthy review of his injuries, incidents, and allegations of neglect. His physician, who briefly attended the meeting, provided the IDT members with an informative, summary of Individual #151's medical status over the past year, which, according to his physician, was "busy" with bouts of aspiration pneumonia, weight loss, tracheostomy, colonoscopy, hospitalizations, etc. After Individual #151's physician presented his summary, due to a scheduling conflict, he was unable to stay for the IDT's review of Individual #151's health risks and needs.	

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		Over the next two and a half hours, Individual #151's IDT proceeded through the list of health risks and attempted to discuss and rate each risk one at a time and apart from other related health risks and relevant aspects of his life. In addition, the review of his health risks failed to include and incorporate relevant family health histories into the discussion and assessment of his health risks. Apparently, the IDT, including the RN case manager, was not knowledgeable of Individual #151's family health history. During the meeting, some IDT members participated much more than others. The conduct of the RN case manager who participated in the ISP meeting needed much improvement. The RN case manager was not adequately informed on a number of health matters, and when pressed by the IDT for more and better health information, he/she quickly became defensive and, on several occasions, stated, "I've only had him [as RN case manager] for a year." It was of concern to the monitoring team that the progress that MSSLC had achieved over six months ago with regard to ensuring 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 had declined. During the review of the 26 sample individuals' records, there continued to be evidence of a pattern of problems ensuring full and consistent implementation of the risk assessment and planning processes. All 26 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and most individuals had one or more "high" health risks. However, of the 26 sample individuals whose records were reviewed, more than half 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. Therefore, this provision item was rated as being in noncompliance. Examples included the following: • On 3/21/12, Individual #99's team agreed that his history of 19 falls in 12 months and vision impairment placed him at high risk for falls. During the six-month period of 3/12-9/12, Individual #99 fell five more times. On one occasion he fell out of his wheelchair, on another occasion he fell when his walker caught on a doorframe, and on yet another occasion her fell after tripping on a rug. Despite the apparent failure of his risk action plan to protect him from harm, there was no evidence that Individual #99's risk action plan was reviewed	

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		or revised, and there were no adequate and appropriate planned interventions to address his continued high risk of falls. • Over the past six months, Individual #365's IDT met several times to review his health risks post-hospitalization and post-injury. Although Individual #365's IDT noted their knowledge of his hospitalization for treatment of pneumonia and sepsis that were likely due to aspiration, poor oral hygiene and high risk of aspiration of bacteria, and pending modified barium swallow study, on 9/24/12, the team concluded that his risk of aspiration was "low." In addition, despite the significant changes in Individual #365's health status and the frequency of his IDT's reviews of his health risks and needs, there were no substantive changes to his 1/25/12 risk action plan. • On 6/6/12, Individual #38's ISPA noted that he was to be referred to the facility's PNMT due to increased episodes of vomiting, hospitalization, and significant history of aspiration and pleural effusion. Curiously, one week later, on 6/15/12, Individual #38's IDT conducted a review of his health risks and noted, "At this time there are no major medical issues. [Individual #38] is doing well. His IRR has been reviewed and there has been no changes made." Thus, at that time, Individual #38's risk of aspiration and respiratory compromise were not raised. Of note, as of the review, despite several episodes of vomiting and risk of aspiration, there was no evidence that Individual #38's IDT followed up with the PNMT to ensure that his health needs and risks were appropriately addressed.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in	The facility's self-assessment reported that, since the prior review, the Medication Error Reduction Committee (MERC) continued to meet on a monthly basis, continued to analyze 16 possible correlates to medication variance, and implemented 11 system and practice changes to aid in the reduction of medication variance. The monitoring team found that the facility did do as reported in the self-assessment, that is, there was analysis of more than 16 correlates and at least 11 different actions were taken in response to the self-assessment activity. In addition, since the prior review, several other steps were taken to further improve the system and processes of medication administration, such as brightly colored medication alert forms were place in individuals' medication administration records (MARs) to alert nurses to individuals who were off-campus, medications with sound and/or look alike names, and medications that were the same name, but different doses/strengths; and the Nursing and Pharmacy Departments developed lists of medications and their associated monitoring parameters, including blood tests. The Nursing Department also continued to conduct hundreds of observations and completed 310 medication monitoring reports of nurses' medication passes and, through this process, identified five nurses for	Substantial Compliance

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	a separate monitoring plan.	remedial education and training. As of the monitoring review, all five nurses who were referred to the Nurse Educator to receive remedial education and training did so, and they demonstrated competence to administer medications, in accordance with generally accepted professional standards of practice. The facility's self-assessment, however, concluded that this provision was not in substantial compliance because "the data reveals that medication errors continue to be problematic and too high." Although, the monitoring team agreed with the facility's characterization of medication errors (i.e., every medication error must be taken seriously and reviewed), the monitoring team's review of this provision found that actions were taken so that nursing procedures were in place, as required by the Settlement Agreement, to "provide the necessary supervision and training to minimize medication errors." Further, the numbers of medication variances reported since the prior review showed a decreasing trend that ranged from a high of 149 in May 2012 to a low of 76 total in August 2012 from the Nursing, Pharmacy, and Medical Departments. Thus, although there continued to be reports of medication variances, there was a decreasing number. Moreover, these data represented only some of the information about the safety of the medication administration system at MSSLC. Of note, a facility that accurately captures and counts errors and critically analyzes its medication use system may have a safer and more accountable system of identifying, reporting, and intervening to prevent harm, even though there are reported medication variances. To be even more specific, after the monitoring team reviewed the document submission, audit reports, medication pass observation forms and reports, months of medication variance data, and meeting minutes; interviewed nurses and nursing leadership; and observed onsite medication administration practices, it was evident that systems and processes were in place to store, deliver, administer, and account for medications, including medication variance, in accordance with generally accepted professional standards of practice. Thus, the monitoring team did not agree with the facility's conclusion of noncompliance, and found MSSLC to be in substantial compliance with provision M6. <u>Storage</u> At the time of the monitoring team's examination of five units' medication areas, all medications were properly stored in locked carts, cabinets, and storage bins. Controlled substances were doubly secured and accounted for by nurses, in accordance with medication logs. Refrigerator temperatures were checked at least daily, and all temperatures were recorded on logs. The refrigerator temperatures on the days of the	

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		monitoring team's reviews were within the proper parameters for medication storage. During all observations, nurses' ensured that the carts, liquid medication bottles, and other tools, such as the pill crusher, were properly cleaned between uses. <u>Administration</u> Observations of six units' systems and processes of medication administration, both oral and enteral, were conducted across the facility at different times of the day and evening by the monitoring team. During all but one observation (on the Martin unit), nurses administered medications in accordance with current, generally accepted standards of care. Nurses properly followed infection control practices, administered medications in accordance with their physicians' orders, reviewed the individuals' PNMP prior to medication administration, treated individuals with respect and dignity, and implemented the steps of the individuals' SAM programs. These findings were indicative of continued improvement in performance from that of prior reviews. The one nurse who failed to ensure that medications were consistently administered in accordance with accepted standards of practice was someone who had already been identified by nursing management as a nurse in need of additional remedial education and training. According to this nurse who was observed, she verified that, on the basis of problems with her performance identified by the facility during their ongoing, regular, monthly audits and observations of medication administration, she had received remedial education and training with the Nurse Educator prior to the monitoring review. Regrettably, during the monitoring team's observations of this nurse's medication pass, continued problems were noted. For example, she failed to change her gloves when she transitioned from "dirty" to "clean" tasks, she recapped a syringe, and she failed to verify that an individual had actually taken his medications before she left his bedroom. The monitoring team reported these observations to the facility's escort – the QA Nurse – who was present on the unit during the observation. <u>Documentation</u> The review of the 26 sample individuals' current MARs for the period of 8/1/12 to 9/30/12 revealed that all MARs were reviewed and signed by a nurse who verified that they were accurate and consistent with the physicians' orders. One-third of the individuals reviewed during this two-month period had two or fewer blank entries on their MARs. This was indicative of continued improvement from what was noted during prior reviews. According to the members of the Medication Error Reduction Committee (MERC), every blank on the MARs was identified and reported as a documentation variance. The plan to address this problem was to increase the frequency of the reviews	

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		of the MARs and to hold counseling sessions with nurses who failed to sign/initial the MARs. According to the Nurse Manager on the Martin Unit, her assistant had implemented a plan to conduct immediate follow-up with the nurses who were responsible for blank entries on the MARs. According to the Nurse Manager, this plan of action was an effective strategy to address and reduce the problem because it sent a clear message to all nurses that "Someone's watching [medication administration] closely." All individuals reviewed had the outcomes of their evaluations for participation in the SAM program referenced in their ISPs, and all individuals observed by the monitoring team participated in some, if not all, of their individualized program or SAM objectives. Documentation of implementation and participation in the SAM program, however, needed improvement. For instance, about half (12) of the 26 sample individuals' MARs reviewed failed to show documentation that their SAMs were consistently implemented twice a day, as recommended. The Health Care Guidelines stated, "The nurse will ensure that each individual will participate in individualized medication awareness [and] each individual will be evaluated for participation in self administration of medication during annual review." This documentation appeared to be an area that was not as closely monitored and scrutinized as were the other areas of medication administration. <u>Oversight and Monitoring</u> According to the generally accepted standards of practice, the goal of a facility like MSSLC was to continually improve systems to prevent harm to patients due to medication errors. They should monitor actual and potential medication errors that occur, and investigate the root cause of errors with the goal of identifying ways to improve the medication-use system to prevent future errors and potential harm to individuals. For over a year, the Nursing Department continued to reconcile medications at delivery and daily, three times a day, at changes of shift. They continued to review MARs for proper and complete documentation, completed PHM9 forms when counts of medications were incorrect, and filed medication error reports when investigations of errors in the counts of medications failed to reconcile or explain the variance. The Program Compliance Nurse and the Nurse Educator conducted 30 to 50 reviews of nurses' administrations of medications per month. They did so in accordance with the state's approved medication monitoring tools. The Nurse managers were required to make all necessary corrections and implement the recommendations for corrective actions within 10 days of the receipt of the "Medication Observation Passes and Medication Administration and Documentation Tool" reports. Of note, although the majority of the reviews were "successful," and most nurses' scored 90% and higher, the Program Compliance Nurse and Nurse Educator still put forward and requested follow-	

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		up to required corrective actions. Interestingly, the Program Compliance Nurse and Nurse Educator's reviews identified problems that were similar to the observations made by the monitoring team during the observations of medication administration. For example, MARs were not complete, nurse failed to ensure that the individual swallowed his/her medications before he/she left the individual, etc. During interviews with Nurse Managers, they were able to provide the monitoring team with evidence of actions taken to ensure follow-up to these findings and implementation of corrective action plans to address the deficiencies. The Medication Error Committee also continued to take steps to reduce errors/unexplained variances and improve practices. MSSLC's monthly medication variance reports indicated that since January 2012, the Nursing Department's medication variances decreased by 53%. In fact, as reported on 9/27/12 by the facility's MERC, "All three areas were down in numbers – nursing, pharmacy, and provider variances were down." However, a review of these data revealed that, over the past six months, there was no straight-line, decreasing trend in medication variances. Rather, there were highs and lows, probably related to the human nature of some of the problems identified and the implementation and effectiveness/ineffectiveness of various corrective action plans implemented in response to findings. Nonetheless, one of the most significant aspects of the MSSLC's medication error reporting and data gathering strategies was that it provided information that helped the facility identify weaknesses in its medication-use system and apply lessons learned to improve the system. The number of errors reported was less important than the quality of the information collected in the reports, the analysis of the information, and the actions taken to improve the system to prevent harm to individuals served. 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. During the three-hour long meeting, old business was reviewed, the effectiveness of follow-up actions was discussed, and a disposition of the topic was made. New business included reports from each Nurse Manager on the monthly medication variances on their units. This lengthy discussion revealed that each Nurse Manager was exceedingly knowledgeable of the contributing factors surrounding the variances and the training and disciplinary actions they took to address the potential and actual errors. Historical medication variance data were reviewed, correlates that may be associated with the variances, such as location, staffing data, discipline, shift, etc., were examined, outcomes of existing plans of correction were highlighted, and the members of the	

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		committee put new plans of correction forward for consideration by the committee and feedback from the monitoring team. Also, the committee was provided with and reviewed extensive lists, tables, graphs, spreadsheets, etc. of the date and time of discovery and notification of error, type of error, location of error, name of medication, immediate actions taken, staff members involved, individual involved, etc. This provided valuable contextual information for the committee's review of medication variance. The Pharmacy Director presented a very interesting analysis of the Pharmacy Department's reconciliation of medications returned to the pharmacy. According to this analysis, during the month prior to the meeting, the pharmacy received 16 PHM9 forms, which accompanied medications that were returned to the pharmacy without an explanation. After an investigation, the Pharmacy Director concluded, "There were only four that were actually medication variances." The Pharmacy Director put forward very good recommendations for the committee to consider. All told, there was extensive, meaningful information that was tracked, recorded, analyzed, interpreted, reported, and acted upon by the facility vis a vis planned interventions and corrective actions to prevent medication errors and reduce the variance in the medication process. During a discussion of the committee's analyses and reporting of medication errors, several issues were raised by the committee for continued discussion, planning, and intervening to improve the facility's practices and procedures surrounding medications: • There appeared to be continued need for physicians to better clarify orders for medications to be administered "now," "STAT," or at the time of the "next dose." • There continued to be improvements needed in MSSLC's current processes and practices of ensuring that allergies to medications were identified and recorded on the MARs. • The after-hour access to certain medications, such as antibiotics, should be clarified with the Pharmacy Department. • There needed to be continued follow-up with WORx experts for software revisions to properly calculate start/stop dates on the MARs. • Modifications to the SAMS program to improve individuals' participation in their program to achieve their goals, such as new medication storage bins, would be investigated. • Revisions to the PHM9 form to improve the medication reconciliation process were underway. • Adding unit dose, liquid medications, such as Miralax, to count sheets was another step the facility planned to take to continue improving the facility's reconciliation of non-pill form and stock medications.	

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		As of the monitoring review, the above initiatives were pending further review and implementation by the committee and/or their designees. The committee's raising of these issues was another indication of the ongoing attention to the continued improvement in the quality of the medication administration program at MSSLC.	

Recommendations:

1. Ensure that nurses consistently document health care problems and changes in health status, adequately intervene, and appropriately record follow-up to problems once identified (M1, M4).

2. Develop ways to help all nurses understand how they should be using the standardized nursing protocols during their daily routines. (M1–M6).

3. Communicate and clarify the expectations and job duties of the Skin Integrity/At-Risk Nurse, especially with regard to the structure, organization, and implementation of his/her duties (M1, M5).

4. Consider providing the Skin Integrity/At-Risk Nurse with additional training/education pertaining to current wound/skin standards of care (M1, M5).

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 content and quality of regularly scheduled comprehensive nursing assessments, such as admission and quarterly nursing assessments (M2).

7. 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).

8. Work together with the Habilitation Department to improve the accuracy and consistency of the recommendations of the PNMP and the MARs regarding medication administration.

9. Continue to ensure that Registered Nurses are visible and available 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. Consider ways to reward nurses' positive performance (M1–M6).

11. Consider ways to decrease vacancies and increase retention (M1 – M6).

12. The facility should consider providing RN case managers with additional training and support to ensure the successful implementation of the integrated health care planning process (M3).

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.2: Medical Care, o MSSLC Self-Assessment for Section N o MSSLC Action Plan Provision N o MSSLC Provision Action Information o MSSLC Organizational Charts o Presentation Book for Section N o MSSLC Policy and Procedure Medical #21 Pharmacy Services, 9/13/12 o MSSSLC Policy and Procedure Medical #29, Quarterly Drug Regimen Review, 8/2/12 o MSSSLC Policy and Procedure Medical #30, Adverse Drug Reactions, 8/16/12 o MSSSLC Policy and Procedure Medical #31, Drug Utilization Evaluation, 8/16/12 o Pharmacy and Therapeutics Committee Meeting Minutes, 3/27/12, 6/25/12, 9/25/12 o Medication Variance Review Committee Meeting Notes, 2012 o Polypharmacy Committee Meeting Minutes o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations • Lorazepam • Statins o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #529, Individual #174, Individual #600, Individual #320, Individual #10, Individual #386, Individual #183, Individual #31, Individual #455, Individual #420, Individual #381, Individual #227, Individual #217, Individual #142, Individual #164, Individual #152, Individual #461, Individual #226, Individual #215, Individual #369, Individual #477, Individual #61, Individual #17, Individual #226, Individual #80, Individual #266, Individual #135, Individual #39, Individual #38, Individual #356, Individual #337, Individual #236 o MOSES and/or DISCUS Evaluations for the following individuals • Individual #457, Individual #67, Individual #253, Individual #592, Individual #74, Individual #489, Individual #143, Individual #281, Individual #154, Individual #427, Individual #216, Individual #341, Individual #374, Individual #92, Individual #8, Individual #381, Individual #540, Individual #398, Individual #850, Individual #385, Individual #700, Individual #31, Individual #169, Individual #593, Individual #164, Individual #195, Individual #103, Individual #415, Individual #139, Individual #499,

	Individual #264, Individual #9, Individual #71, Individual #257, Individual #377, Individual #143, Individual #248, Individual #281, Individual #427, Individual #53, Individual #310, Individual #215, Individual #304, Individual #369, Individual #477, Individual #17, Individual #226, Individual #80, Individual #266, Individual #61, Individual #215 Interviews and Meetings Held: o Anyssa Garza, PharmD, Pharmacy Director o Esteban Rodriguez, PharmD, Clinical Pharmacist o Abigail Okeke, PharmD, Clinical Pharmacist o Dolores Erfe, MD, Medical Director o Angela Johnson, RN, Medical Compliance Nurse o Chris Ellis, MD, Primary Care Physician o Bernardo Gutierrez MD, Primary Care Physician o James Gilley MD, Primary Care Physician o Kendall Brown MD, Lead Psychiatrist o Madhu Rao MD, Staff Psychiatrist o Juanita Kirby, MD, Staff Psychiatrist o William Thomas PA o Norris Buchmeyer, Chief Nurse Executive o Karen Wilson RN, QA Nurse Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Reduction Committee Meeting o Polypharmacy Oversight Committee Meeting o Daily Clinical Services Meetings o Medical Review Committee Meeting
	Facility Self-Assessment: MSSLC submitted three documents as part of the self-assessment process: self-assessment, action plan, and the provision action information. For each of the provision items, the pharmacy director listed the activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. This was an acceptable approach to completion of the self-assessment. To help move this process forward, during the compliance review, the monitoring team reviewed each provision item with the pharmacy director, noting those areas emphasized by the monitoring team. The pharmacy director should carefully read this report with attention given to those areas reviewed by the monitoring team and ensure that that those items are included in the next self-assessment.

	The facility rated itself in substantial compliance with provision items N1, N2, and N7. For provision items N3, N4, N5, N6, and N8, the facility rated itself in noncompliance. The monitoring team found the facility to be in substantial compliance with provision items N2, N4, and N7. The facility remained in noncompliance with provision N1, N3, N5, N6, and N8.
	Summary of Monitor's Assessment: The pharmacy was fully staffed with a pharmacy director, two clinical pharmacists, one registered pharmacist, and four technicians. Significant progress was made in the provision of pharmacy services and safe medication practices under the leadership of the pharmacy director. During her one-year tenure, a series of changes had been implemented that were beginning to have a considerable impact on many practices in several departments. The documentation of communication between the pharmacists and prescribers improved, although the actual number of interventions appeared somewhat low. This may have been influenced by a failure to notify prescribers of moderate drug interactions. The facility successfully implemented the Intelligent Alerts in June 2012, but no system had been developed to provide documentation to show that this was actually completed for each new order when indicated. The QDRR process was greatly improved relative to content and medical staff response times. This was largely in response to process changes in which the evaluations became available electronically for review. The facility continued to have difficultly completing the MOSES and DISCUS evaluations. Those that were completed often did not take into consideration significant findings. Moreover, practitioners, such as primary providers and neurologists, did not appear to utilize the evaluations in clinical decision making. Adverse drug reactions were reported, but it was not clear that this information was being adequately analyzed for trends and patterns, although prior ADR data appeared to be the source of future DUEs. ADR training for nursing and direct care professionals was implemented only days prior to this compliance review. Drug utilization evaluations were completed as required and provided good information for facility staff. The pharmacy department, however, was limiting its DUE selection to drugs based on ADR data and will need to broaden its selection to capture more high risk and high use agents. Finally, progress was noted in the medication variance program. The program appeared more structured with increased meetings and data analysis. With increased attention in this area, new problems were continuously surfacing, several of which were significant and were being addressed at the time of this compliance review. The facility will need to continue to work to improve in this area.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.</td><td>This provision item is related to fundamental components of the medication use system – the prescribing and dispensing of medications. The pharmacy department completed prospective reviews 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.

Clinical interventions and review of physician orders continued to be documented by the pharmacy department. The monitoring team requested copies of all clinical interventions documented since the last onsite review. Clinical Intervention Forms and Review of Physician Order Forms were submitted along with the Notes Extracts. Summary data are presented in the chart below.

<table>
<tr><td colspan="7">Pharmacy Documentation 2012</td></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td></tr>
<tr><td>Clinical Intervention</td><td>10</td><td>6</td><td>16</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>Review of Physician Orders</td><td>20</td><td>12</td><td>18</td><td>16</td><td>13</td><td>25</td></tr>
<tr><td>Total Issues Documented</td><td>30</td><td>18</td><td>34</td><td>30</td><td>26</td><td>37</td></tr>
<tr><td>Total Orders</td><td>--</td><td>1386</td><td>1649</td><td>1214</td><td>--</td><td>--</td></tr>
</table>

The clinical intervention log documented the types of recommendations made to the prescribers, the responses of the prescribers, and the outcomes. Recommendations were made regarding therapeutic duplication, avoidance of ADRs, drug interactions, and administration. The most frequently documented interventions were related to therapeutic duplication.

The review of physician orders log provided information on the medications, order issues, method of communication with prescribers, prescriber responses, and outcomes. The issues documented most frequently were missing stop dates and routes of administration.

The data from both of these documents was submitted monthly to the medical director. The minutes of the Medical Review and Pharmacy and Therapeutics Committees documented discussion of the issues. As a corrective action, all medical staff were granted access to WORx universal so that prescribers were able to review the medication profiles of individuals. The pharmacy director believed this would decrease the amount of interventions related to therapeutic duplication. Moreover, the medical director and CNE were both provided with the review of physician orders log. The CNE noted during the P&T meeting that nurses were being encouraged to review all orders for completeness and accuracy prior to faxing orders to the pharmacy.

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</td><td>Noncompliance</td></tr>
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		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." To that end, in June 2012, the facility implemented the Intelligent Alerts, which required laboratory monitoring for seven drugs including carbamazepine, dilantin, valproic acid, phenobarbital, lithium, levothyroxine, and warfarin. In addition to the required clozapine monitoring, additional monitoring related to acetaminophen, statins, and digoxin were also implemented. Training on this required process was completed at the end of August 2012. While the pharmacy director reported that this lab monitoring was completed, there was no documentary evidence that the required checks were completed for <u>every relevant order</u>. A total of eight clinical interventions related to lab monitoring were documented for the reporting period. One disturbing finding noted during this review was the pharmacy's director's report that the WORx system was set to flag only severe drug interactions. Mild and moderate interactions were not noted and, therefore, not reported to the medical staff. Overall, the pharmacy department made significant progress in this area, although the total number of interventions appeared very low based on the total number of orders. Achieving substantial compliance will require several additional steps including: • Increased documentation of interventions • Collaboration with the medical staff to identify other drugs that require important lab monitoring prior to dispensing • Development of a system to document that the required monitoring occurs in accordance with facility requirements • Implementation of an appropriate drug alert threshold • This provision remains in noncompliance.	
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.	The pharmacy department implemented several changes to the Quarterly Drug Regimen Review process. The clinical pharmacist notified the PCPs and psychiatrists when the QDRRs were completed and available for review on the shared drive. The prescribers were also provided with the deadlines for their responses to the reviews. The documents were, therefore, reviewed and signed electronically. A total of 32 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	Substantial compliance

		diagnostics associated with drug use. There was significant improvement noted in the content of the QDRRs. For each medical condition, the clinical pharmacist cited the drug used and listed the associated monitoring parameters. In the case of laboratory values, the exact values and dates were usually provided. It was usually, but not always, noted if the value was high, low, or normal. Comments were found regarding blood pressures and heart rate for individuals receiving antihypertensive medications. Since the last review, the clinical pharmacist made more formal recommendations as opposed to making comments. The documentation of formal recommendations required that the prescribers respond by agreeing or disagreeing with the recommendations. Recommendations made by the clinical pharmacist included: • Consideration of discontinuing PRN medications that were not frequently used • Obtaining EKGs and lab studies related to psychotropic use • Completion of MOSES and DISCUS evaluations that were outstanding • Referral for annual eye exams • Assessing compliance with diet and medications for uncontrolled diabetes • Obtaining overdue DEXA scans • Decreasing Ativan possibly related to dizziness and falls While the content was more robust, the monitoring team noted that there was opportunity for improvement in the completion of the QDRRs. The clinical pharmacist could have made even more substantive recommendations in several instances. The following are a few examples: • Individual #31, 5/17/12: There was no discussion of the diagnosis of anemia or the MCV of 76. • Individual #38, 6/15/12: There was no discussion of anemia. • Individual #320, 6/29/12: The individual was on divalproex for "seizure disorder by history," but the seizure frequency monitoring section of the worksheet was incomplete. If the diagnosis was not clear, a recommendation should have been made for a neurology evaluation. If the medication was not needed for seizures, but needed for a psychiatric indication, it would be appropriate to change the indication after neurological evaluation. • Individual #350, 7/5/15: Loratadine was prescribed for allergies. The use of appropriate ICD nomenclature is required. Therefore, the clinical pharmacist should make recommendations to use appropriate indications, such as allergic rhinitis or urticaria. • Individual #337, 6/29/12: Trazodone was indicated for the management of sleep. Again, this was not consistent with the required ICD nomenclature.	

		• Individual #236 8/3/12: The only parameters for diabetes management cited were glucose and HbA1c. There was no discussion of the urinary protein assessment or podiatry evaluation. The individual did not have tight glucose control. Overall, there was significant progress in this provision item. There was improvement in the content provided by the clinical pharmacist. Moreover, the response time by the PCPs and psychiatrists improved significantly since the previous compliance review. The pharmacy director will need to ensure that the documents are not edited once they are signed by all parties. At the time of the onsite review, there was no means of ensuring the integrity of the documents meaning that they could be altered by anyone with access at any given time. Based on the adequacy of content and timeliness of completion of the Quarterly Drug Regiment Reviews, this provision item achieved substantial compliance.	
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 and Benzodiazepine Use</u> The use of stat medications and benzodiazepines was documented in the QDRRs. For each use, there was a comment related to the indication and the effectiveness of the medication. The use of PRN meds is discussed further in section J. <u>Polypharmacy</u> Polypharmacy was addressed in every QDRR reviewed. The comments were usually limited to the existence of polypharmacy. In some reviews, the clinical pharmacist provided recommendations to decrease non-psychotropic polypharmacy, but this was not consistently noted. Psychotropic polypharmacy and the Polypharmacy Oversight Committee are addressed in further detail in section J. <u>Anticholinergic Monitoring</u> Each of the QDRRs commented on the anticholinergic burden associated with drug use. The risk associated with each drug was stratified as low, medium, or high. There were no specific recommendations to decrease the anticholinergic burden, but recommendations were sometimes, but not consistently, noted regarding discontinuing unnecessary medications. <u>Monitoring Metabolic and Endocrine Risk</u> The facility monitored individuals for the metabolic risks through the QDRRs. The QDRR worksheet included a table that listed waist circumference, triglycerides, HDL, blood pressure and fasting glucose. It also included a statement regarding overall risk for metabolic syndrome. While, the independent monitoring parameters for metabolic	Noncompliance

		syndrome were consistently cited on the report form, the overall risk assessment was not and should have been. The QDRR, inclusive of the worksheets, was a very lengthy document. The reader should be able to glean the most important information from the actual report form. This provision remains in noncompliance due to the need to do additional work in the area of polypharmacy oversight.	
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. Based on record reviews, the providers accepted the majority of recommendations made by the pharmacists during the retrospective reviews (QDRRs). For the records included in the record sample, there was evidence that when most providers accepted the recommendations of the pharmacist, there were follow-up actions, such as ordering of labs, changing medication doses, etc. Explanations were provided on the QDRR report when the recommendation was not accepted. Therefore, this provision moved into substantial compliance. The monitoring team recommends that with full pharmacy staffing, the pharmacy department maintain some data related to this provision item.	Substantial Compliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	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: Forty-nine MOSES evaluations were reviewed for timeliness and completion: • 49 of 49 (100%) were signed and dated by the prescriber • 44 of 49 (90%) documented no action necessary • 3 of 49 (6%) documented actions taken, such as drug changes and monitoring Forty-eight DISCUS evaluations were reviewed for timelines and completion: • 48 of 48 (100%) were signed and dated by the prescriber • 38 of 48 (79%) indicated no TD • 7 of 48 (15%) indicated the presence of TD Facility procedure required completion of both evaluations on a quarterly basis. The facility maintained data on the timeliness of completion. Based on the QDRRs completed by the clinical pharmacist, the facility reported that 25% of evaluations were not in compliance during the months of January 2012 through March 2012. For the months of April 2012 through June 2012, 16% of evaluations did not meet compliance. The pharmacy director acknowledged during interviews that many forms were simply being	Noncompliance

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<td>signed by the medical staff without having the appropriate sections completed. She reported that this was being addressed and some improvement had been noted.

The monitoring team noted for the evaluations reviewed as part of the record sample, that, on average, 44% of the MOSES and/or DISCUS evaluations were not completed in a timely manner. Moreover, the majority of the evaluations included no remarks or comments by the prescriber, even when scores were high or issues were identified.

Although these rating instruments served as a valuable source of information, record reviews did not reveal any evidence that this information was utilized by the primary providers or the neurologists in clinical decision making. The monitoring team has and continues to recommend that the primary care providers and neurology consultants review this information.

This provision item remains in noncompliance. In order to achieve substantial compliance, the facility must demonstrate that these evaluations are thoroughly completed in a timely manner. Moreover, the information must be utilized in clinical decision-making. In order for this to occur, the data must be reviewed by the primary providers in addition to being reviewed by the psychiatrists and neurologists.</td>
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<td>N6</td>
<td>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.</td>
<td>The facility's ADR policy was revised to include a description of the reporting process, the responsibilities of each discipline, and the requirements for an intense case analysis. ADRs were discussed monthly in the Medical Review Committee meeting as well as the quarterly Pharmacy and Therapeutics Committee meetings. The pharmacy director maintained a spreadsheet of all ADRs. The information documented included the date of reaction, reporting staff, medication(s) involved, description of reaction, type of reaction, severity and probability scales, and risk probability number. The number of reported suspected ADRs is presented in the table below.

<table>
<tr><th colspan="6">ADRs 2012</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th></tr>
<tr><td>Number of ADRs</td><td>39</td><td>24</td><td>25</td><td>18</td><td>5</td></tr>
<tr><td>% Reported by Medical Staff</td><td>10</td><td>13</td><td>20</td><td>6</td><td>0</td></tr>
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The majority of ADRs reported were related to the use of psychotropics or AEDs. In fact, 85% of ADRs reported during the months of March 2012 through May 2012 implicated psychotropics, AEDs, or both classes of drugs. During discussions with the pharmacy director, it was noted that analysis and trending of these data to determine the presence of patterns had not occurred. The monitoring team observed that the DUE calendar was scheduled through September 2013 based on ADRs reported from September 2011 – January 2012 and these DUEs were to be completed on AEDs and psychotropics. The monitoring team would like to emphasize that ADR data that indicates patterns or trends</td>
<td>Noncompliance</td>
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		should be addressed immediately via the DUE or other appropriate processes. The pharmacy director also reported that several ADRs reached the threshold for intense case analysis. The P&T agenda, dated 6/25/12, documented that four ADR cases met the threshold for review, but no additional information was provided. The agenda also noted that the ADRs for April 2012 and May 2012 "will be discussed at the upcoming MRC meeting and any follow-up will be discussed at the P&T meeting." The monitoring team attended the Pharmacy and Therapeutics Committee meeting held on 9/25/12 and observed that the meeting included a very brief summary of three additional cases that met the threshold for an intense review. The summaries were documented on the agenda and in the minutes for the meeting. The facility also identified other issues related to ADRs and drug allergies. For example, the pharmacy department's review of random orders from 7/30/12 to 8/3/12 showed that physician orders involved inconsistent allergies. These discrepancies placed individuals at risk for medication errors related to drug allergies. The facility continued to work towards providing the necessary training on the ADR monitoring and reporting system. ADR training tools were developed including a Power Point presentation. The medical staff was trained and the nursing department began training on 9/18/12. The ADR presentation was incorporated into new employee orientation on 9/20/12. As noted in previous reviews, the agenda of the Pharmacy and Therapeutics Committee should have a designated section for the disposition of each discussion, however, the disposition and discussion should be a product of the actual meeting and should not be predetermined and documented on the agenda prior to the meeting. The agenda should serve as the roadmap for the meeting. In order to achieve substantial compliance, the facility will need to take several steps related to the ADR monitoring and reporting system: • There should be increased reporting by the medical staff. • All ADRs should be reported to the Pharmacy and Therapeutics Committee. This committee is charged with reviewing ADR data, analyzing the data for patterns or trends, and developing preventive and corrective actions. The ADR form should reflect the final determination by the P&T Committee and should be signed by the chair. The committee should also receive follow-up on the status of the corrective actions. The Medical Review Committee may be utilized as a means of providing immediate feedback and discussion related to ADRs for the medical staff. • There should be continuous monitoring of individual and aggregate data. • Opportunities for educational efforts to train on prevention of ADRs should be identified. The Medical Review Committee meeting provides a good forum for	

		educational activities. • 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 discipline-specific training on the recognition of ADRs and the facility's reporting process. • The pharmacy director will need to review the criteria for the ICA and develop a specific process for intense case analysis. This is an important component of the risk management process. The criteria for review should ensure that cases are appropriately reviewed in a timely manner and the findings formally presented to the Pharmacy and Therapeutics Committee. This provision remains in noncompliance.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility's DUE policy required completion of one DUE each quarter. DUE reports on lorazepam and statins were provided for review. Both reports included background information, objectives, criteria, methods results, conclusions, and recommendations. The findings were presented at the Pharmacy and Therapeutics Committee meetings. Summaries of the information presented in the DUE reports are presented below. The DUE Lorazepam: Proper Use of Benzodiazepines was presented to the Pharmacy and on 6/25/12. The objective of the evaluation was to evaluate the appropriate use of this medication as well as to determine if a correlation existed between the medication and the presence of behavioral side effects. Thirty-one individuals who received lorazepam were reviewed. Indications, dosing, the number of falls, behavioral side effects, and restraint use were assessed. The evaluation showed that: • Thirty two percent of individuals were prescribed the drug for a FDA approved indication or for a non-label indication. • There was one non-reported ADR. • There was no positive correlation between agitation and aggressive behavior and dose changes. Recommendations generated by the DUE included: • The medical staff should engage in further review of medication indications. • The facility should develop protocols for benzodiazepine tapers. • Development of systems to correlate falls with medications was needed. The recommendations and action steps were not recorded in the minutes and the document request referred the monitoring team to the MRC minutes for 6/27/12. Those	Substantial Compliance

		minutes were requested following the compliance review, but did not include additional information. The DUE on statins was presented in the P&T meeting on 9/25/12. The objective of the DUE was to ensure that individuals at MSSLC received optimized statin therapy according to national current standards. This study also reviewed drug selection, drug administration, drug dose, and lab monitoring. Seventy individuals received treatment with statins. Approximately 21% of the individuals were randomly chosen for review. Justification for drug use, appropriateness of dose and administration times, lab monitoring, drug interactions, and target lipids were reviewed. The study determined that all of the individuals studied had appropriate statin administration times. It was also demonstrated that the majority of the individuals in the study group had excellent fasting lipid panels. Recommendations generated by the DUE included changes in the lab matrix, such as the removal of the requirement for routine liver enzymes and the addition of more frequent monitoring of glucose status. Overall, the DUEs were adequate and provided good information for the facility staff. The September 2012 P&T Committee meeting also included a discussion of the next DUE to be completed, on Risperdal. The committee was provided the audit tool, which included the proposed indicators for the Risperdal DUE. In accordance with the facility's DUE policy, the Pharmacy and Therapeutics Committee provided oversight for the process. The committee was responsible for determining the indicators to be measured, the data collection form, sample size, and the thresholds for compliance. Additionally, the committee was responsible for developing and implementing the corrective action plans. The committee minutes should, therefore, include appropriate and through documentation of the recommendations and the specific corrective action plans. While this information may be presented and summarized at the MRC, the Pharmacy and Therapeutics Committee is charged with oversight of the process. The monitoring team needs to emphasize that the selection for DUEs should not be limited to information based on ADR data. The Health Care Guidelines provide specific guidelines on selection criteria, which includes high use and high risk agents. It may be necessary in some instances to conduct more than one DUE per quarter.	

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<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 and progress was noted with regards to the reporting of medication errors and corrective actions implemented. The medication data provided to the monitoring team are summarized in the tables below.

<table>
<tr><th colspan="7">Medication Variances 2012</th></tr>
<tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th></tr>
<tr><td>Nursing</td><td>59</td><td>45</td><td>77</td><td>63</td><td>78</td><td>63</td></tr>
<tr><td>Pharmacy</td><td>16</td><td>21</td><td>48</td><td>59</td><td>53</td><td>21</td></tr>
<tr><td>Provider</td><td>13</td><td>13</td><td>20</td><td>12</td><td>18</td><td>16</td></tr>
<tr><td>Total</td><td>88</td><td>79</td><td>145</td><td>134</td><td>149</td><td>100</td></tr>
</table>

The CNE chaired the Medication Variance Reduction Committee. It was reported that the meeting occurred monthly, but the document request provided meeting minutes for only April 2012 and May 2012. The monitoring team attended this meeting during the week of the onsite compliance review. The meeting was lengthy and included a review of data as well as a number of a number of actions that occurred with the intent of reducing medication variances at MSSLC including:
• A Review of Physician Order Sheet was implemented and placed near all fax machines to aid staff in reviewing orders for completeness prior to faxing to the pharmacy.
• Changes in medication ordering were implemented to prevent weekend depletion of medications.
• Bright note cards were placed in medication carts to remind nurses to be cautious in administration of certain medications.
• The pharmacy medication audit criteria were revised to help minimize variances attributed to improper storage and to avoid expired meds being available in the homes.
• RN Managers, RN Case Managers and physicians were granted access to WORx Universal for use in viewing medication profiles and allergies.

Notwithstanding these noteworthy changes, the facility required much additional work in this area. During discussions with the pharmacy director, it was highlighted that reconciliation of stock items remained an outstanding issue. Several medications had transitioned to unit doses, but the changes were ongoing. During the conduct of recent medication room inspections, a considerable amount of expired medications was noted to be available for use. Finally, as noted in section N6, inconsistencies in allergy listings left individuals at risk for medication variances related to allergies. Given the significant progress made over the past six months, the monitoring team is confident that the identification of these issues will result in a series of steps leading to corrective actions.

This provision item remains in noncompliance.</td>
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Recommendations:

1. The facility will need to take a number of steps in order to move towards compliance with Provision N1. The monitoring team offers the following recommendations for consideration:
    a. The documentation of communication with prescribers should be increased.
    b. There should be clear documentation of the prescriber who is contacted and the time of contact.
    c. The procedure for management of all drug interactions should be clearly delineated. Pharmacists and prescribers should all be aware of this process. Severe drug interactions should require direct communication with the prescriber and written information should be provided in the form of the drug monographs.
    d. The pharmacy director will need to collaborate with the medical director/medical staff to expand the list of drugs monitored as part of the Intelligent Alerts.
    e. The facility will need to have documentation that the intelligent alerts occurred as necessary. The WORx system may be capable of providing a report of this. Pharmacists could potentially just note this in a simple log (N1).

2. The following actions should be taken into consideration with regards to the QDRR:
    a. The QDRR Report should comment on every medication that is included in the lab matrix. The exact value should be provided with the date as well as an indication of the range of values.
    b. The clinical pharmacists will need to continue to capture relevant clinical recommendations. Recommendations should cover all areas including the reduction of polypharmacy and anticholinergic burden (N2).

3. The medical director should ensure that all medical staff have received proper training on the MOSES and DISCIS evaluations and understand the requirements for completion (N5).

4. The primary care physicians should review the information included in the MOSES and DISCUS evaluations and utilize the information in clinical decision making. Consideration should be given to including this information in the annual and quarterly assessments (N5).

5. The facility should provide the MOSES and DISCUS evaluations to the consulting neurologists for use during consultation (N5).

6. The facility should take multiple actions with regards to the ADR reporting and monitoring system:
    a. The ADR policy should specify how the reporting form is completed.
    b. ADRs should be reviewed by the primary provider, pharmacy director, and medical director. All three should be required to sign the ADR reporting form. The chairperson of the Pharmacy and Therapeutics Committee should sign the form after the final determination is made by the committee.
    c. The form should indicate who initiated it (reporter).
    d. The facility must ensure that all medical providers, pharmacists, nurses, 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
    e. Additional recommendations are contained in the body of report (N6).

7. The pharmacy director and medical director should ensure that changes made related to DUEs to the lab matrix do not cause conflicts with any monitoring requirements found in state issued laboratory monitoring protocols (N7).

8. Changes in laboratory monitoring protocols should take into consideration the special needs of individuals with developmental disabilities (N7).

9. The facility must ensure that appropriate reconciliation of all liquid medications is being completed and documentation is being maintained in a format that can be retrieved and reviewed (N8).

10. The medical, nursing and pharmacy departments should continue their collaborative efforts to ensure that allergy discrepancies are promptly resolved (N8).

11. The facility must implement the appropriate systems to ensure that expired medications are removed promptly form medication rooms (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 PNMT Staff list and Curriculum Vitae o Staff PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section O-Physical Nutritional Management o PNMT Process document (9/25/12) o PET Monthly Worksheet o SSLC Policy 012.2 Physical Nutritional Management (4/23/12) o PNMT Assessment template o PNMT Meeting documentation (9/1/12 to 9/27/12) and notes o PNMT referrals submitted o PNMT meeting dates o PNMT Assessment drafts (Individual #341, Individual #188, Individual #533, and Individual #151 o Individuals with PNM Needs o Dining Plan Template o PNMP Monitoring template o PNMP Monitor the Monitor template o PNMP Monitoring sheets submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Hospitalizations for the Past Year o Summary List of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o List of Individuals with Aspiration and/or Pneumonia o List of Pneumonias in the Past Year o Individuals with Pain o Individuals with Choking Incidents and related documentation o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months

	o Individuals Having Falls Past 12 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o Skin Integrity Spreadsheet o Individuals with Fractures Past 12 Months 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 Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPs submitted o List of Individuals with MBSS o PNM Maintenance Log o Adaptive Equipment Spreadsheet o Wheelchair evaluations submitted o APEN Evaluations: • Individual #266, Individual #188, Individual #302, Individual #35, Individual #511, Individual #61, and Individual #257. 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #432, Individual #533, Individual #281, Individual #140, Individual #120, Individual #369, Individual #178, Individual #197, Individual #435, Individual #341, Individual #436, Individual #72, Individual #38, Individual #226, Individual #188, Individual #427, and Individual #291, Individual #477, Individual #151, Individual #391, Individual #257, and Individual #1. o PNMP section in Individual Notebooks for the following: • Individual #432, Individual #533, Individual #281, Individual #140, Individual #120, Individual #369, Individual #178, Individual #197, Individual #435, Individual #341, Individual #436, Individual #72, Individual #38, Individual #226, Individual #188, Individual #427, and Individual #291, Individual #477, Individual #151, Individual #391, Individual #257, and Individual #1. o Dining Plans for last 12 months, PNMPs for last 12 months, Aspiration Trigger Sheets for the following:

	• Individual #432, Individual #533, Individual #281, Individual #140, Individual #120, Individual #369, Individual #178, Individual #197, Individual #435, Individual #341, Individual #436, Individual #72, Individual #38, Individual #226, Individual #188, Individual #427, and Individual #291, Individual #477, Individual #151, Individual #391, Individual #257, and Individual #1. Interviews and Meetings Held: o Brandie Howell, OTR Habilitation Therapies Director o Sandra Opersteny, PT o Harvey Evans, OTD, OTR o Lisa Finley, COTA o Karen Fleming. COTA o Various supervisors and direct support staff o PNMT meeting o ISP Meeting for Individual #151 Observations Conducted: o Living areas o Dining rooms o Day Programs and work areas
	Facility Self-Assessment: Based on review of the self-assessment, Brandie Howell, OTR, the Habilitation Therapies Director, attempted to outline specific assessment activities, however, most of these would not lead the facility to achieve compliance with this provision. There were no measurable outcomes established and some of her findings were inconsistent. For example, she reported that 75% of the enteral feeding assessments (APEN) were completed, yet another finding was that only 7 of 32, or 22% were completed. She also presented other information, such as there being 83 PNMPs that required revision. This finding did not have any meaning or context and, as such, was not useful in any way. She reported that five PNMT assessments were completed, yet only two appeared complete in the last six months and four remained incomplete for as many as seven months. These same types of data were presented in the PET meeting and were not useful in the analysis of status or progress toward compliance. The Presentation Book provided a plethora of documents, many of which did not clearly relate to the action plan or self-assessment activities. There was no effective analysis of the findings, accomplishments, and work products. While the existing audit tool was referenced, it was not heavily relied on for self-assessment. This was a positive step because many of its elements were not useful. As recommended during the previous review, this tool should be revised to better reflect what is meaningful. All but one of the elements were reported as 100% and, as such, did not drill down to what was needed to further assess areas needing improvement. The activities for self-assessment listed for each provision were numerous and will not be listed here. The

	findings were presented in narrative form and it may be useful to supplement that with data in a graph or table format to illustrate change and improvements over time. An action plan to address identified issues should illustrate how Ms. Howell would intend to proceed toward compliance. The facility self-rated itself as noncompliant with each of the eight elements of O (O1 through O8). While there were some actions taken in the direction of substantial compliance, there was also some regression. The monitoring team also found that all provision items were not in compliance. Overall, there had been little change in the status for this provision during the last six months.
	Summary of Monitor's Assessment: Minimal progress was made towards substantial progress with provision O. The level of staffing for the PNMT was significantly decreased. The team generally met on a near-weekly basis, but the attendance by most of the team members was not acceptable. During the previous review, the monitoring team had expressed serious concern that the PNMT assessments were taking too long to complete. There was an example of one that took approximately five months. This time, only two assessments were submitted as complete in the last six months, none in the last two months, and at least four had remained incomplete as long as seven months. An evaluation of this nature should not take more than 30 days (or even 45 days given special circumstances related to the individual). There was little analysis of findings and the assessments were lacking in clinical reasoning used by the team for the development of interventions and supports. There was no clear link to the mitigation of health risks and health status, and many of the recommendations were of minor significance in addressing these. For example, some related to changes in language or format of the PNMP rather than substantive interventions. Findings of monitoring were not reported in the assessments. There was no formal audit of the assessments and no written content guidelines. One of the reasons given for the delays in some reports was that they were converted to a new format after a delay of almost five months. There were a number of referrals discussed at the PNMT that had been received several weeks before the meeting, but had not yet been addressed. One referral was still outstanding since the individual's ISP meeting in February 2012, after three requests by the team. By report of the habilitation director, the paperwork had been returned to the QDDP because it had not been properly completed. During the ISP observed, it was reported that there was an outstanding referral for suction toothbrushing since June 2012 and it was not even referenced at the PNMT meeting. This was for one of the individuals who had not yet received a completed PNMT assessment since February 2012. The only outcome for the referrals that were documented during the meeting was that the director and a new SLP would complete them. There was no timeframe established. There was discussion in response to the monitoring team's question about the incomplete assessments. There was disagreement among the team as to whether they were actually completed and waiting for the director to review them. She indicated that they had not yet submitted a complete assessment. Regardless, it was the director's responsibility as director and chairperson of the PNMT to ensure that they were completed properly and in a timely manner.

	The PNMT did not appear to be routinely and proactively reviewing individuals with a high risk of key PNM indicators or with incidences of these concerns. They did not routinely track their status in an organized manner, but rather tended to wait for a referral that there was a problem. Follow-up of individuals they provided assessment or review of was inconsistent and not well documented. Mealtimes, position, and alignment were adequate in most cases, though one dining room was of significant concern due being short staffed, the DSPs not following the plans, and DSPs not knowing the health risks of the individuals. The mealtime environments were essentially just getting the job done and were not dynamic and pleasant environments. A number of individuals would likely benefit from modified dining chairs to accommodate their needs for support and alignment during meals. Day programs should be an area of focus for positioning monitoring and assessment.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility	Core PNMT Membership: The current core team members of the PNMT listed included Brandie Howell, OTR, Director of Habilitation Therapies, Rosemary Roberts, RN, Sandra Opersteny, PT, and Assistant Director of Habilitation Therapies, Mary Bennington, MA, CCC-SLP, Jennifer Capers, RD, and Christopher Ellis, MD. There were no clinicians assigned full time to the PNMT and each had additional duties. There had not been a nurse team member since July 2012 when the previous nurse resigned from the position. Ms. Roberts had very full time responsibilities as the hospital liaison. She was described as the back-up nurse for the PNMT. She had not attended any meetings until the one observed by the monitoring team on 9/27/12. Mary Bennington was no longer employed at MSSLC, having completed only two months of a 26-week assignment. She replaced the previous SLP who resigned in May 2012. By report, there was another replacement SLP in NEO at the time of this onsite review by the monitoring team. The full time OT assigned to the PNMT had resigned in June 2012 and there was no replacement for him, though the director was an OT. The dietitian was the only licensed dietitian for all 371 individuals and was the RD on the PNMT. Both Ms. Howell and Ms. Opersteny had numerous other duties as directors within the habilitation therapies department. Continuing Education Continuing education was documented for some of the current core members of the team in the last six months and included the following. Some were attended by one or more core team members, though not all had contact hours or CEUs listed: • Pressure Ulcer webinar • Comprehensive Clinical Management workshop • Trauma Care workshop • Transforming Principles into Practice (6.5 hours) • Nestle Thickener Products • Memory (6 hours)	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Seating: Bottom to Top and Standing Justified (6.25 hours) This level of continuing education was adequate, though some of the team members listed were no longer employed at MSSLC. It is critical that this team continue to achieve and maintain the highest possible knowledge and expertise in the area of PNM. Consideration of continued PNM-related continuing education opportunities for all team members, in addition to the state-sponsored conferences/webinars, should be a priority. Cross-training in areas traditionally viewed as pertaining to a specific discipline would also be highly useful to enhance team building and the interdisciplinary approach. <u>Qualifications of Core Team Members</u> Background and experience for the current team members was reported in previous reviews. Each had multiple years of experience with individuals with developmental disabilities and PNM. Current licenses to practice in the State of Texas were verified for team members. <u>PNMT Meeting Frequency and Membership Attendance</u> There were 20 meetings held from 4/6/12 through 9/21/12. Minutes were submitted for two other meetings: 6/22/12 stated that a meeting was not held because the RN and PT were not available, and 8/10/12, but only the PT was marked present. Attendance during that period was: • Chairperson: 40% • RN: 60% • PT: 88% • OT: 36% • SLP: 32% • RD: 28% • MD: 0% This attendance frequency was not acceptable for any team member. There should be back up clinicians assigned, so that meetings may be held to address issues for the individuals served with high PNM needs and significant at-risk concerns. It was of note that the designated chairperson attended less than half of the scheduled meetings, as was also true of each of the team members (other than the PT and RN). The physician had not attended any meetings since the previous review. During this most recent meeting observed, there was no OT or SLP present and it was the first meeting for the nurse in attendance as the back-up. As stated above, there was a gap in SLP attendance for two months, from 5/4/12 to 7/6/12 and again since 8/24/12. There was no designated OT assigned to the team since 6/8/12 and the director who was an OT had attended only five meetings since that time. There had been no RN on the team since 7/27/12.	

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		Role of the PNMT: Facility PNMT Policy The state PNMT process was outlined in a policy that described the referral process and PNMT member responsibilities. Appropriate referrals included individuals at high risk who were not stable and/or for whom the IDT required assistance in the development of an intervention plan to address PNM concerns. This included the IDT, of which the PCP was a member, and self-referrals by the PNMT based on review of key clinical indicators. There was a PNMT Process document submitted, revised on 9/25/12. It was not identified as formal or approved MSSLC policy. It stated that it was based on the DADS SSLC policies for PNMT and At Risk Individuals. This document did not appear to have been operationalized for use at MSSLC. As described below, the PNMT did not adhere to the timelines or some of the procedures and processes outlined.	
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.	PNMT Referral Process The PNMT document outlined that the IDT, PCP, or PNMT could refer individuals to the PNMT. It was stated that the referral should include the following information: • Reason for referral • Health data information • Current assessments • Risk ratings and rationales • Action plan • ISP addendum relating to the action plan This document indicated that the team would meet within five days of a referral to (1) review and analyze existing assessments and recommendations, (2) discuss previous interventions by the IDT, and (3) to determine the PNMT Level of Intervention. There were four levels as follows: • Level I: High Risk (full assistance from the PNMT) • Level II: High or Medium Risk (oversight/consultation from the PNMT • Level III: Individuals formally followed by PNMT, but stable with supports in place • Level IV: Review or oversight of individuals by the PNMT related to other reasons (concerns identified at daily rounds, hospitalization, action plan review, changes in status, among others) There was no evidence in the meeting minutes that individuals reviewed by the PNMT were assigned to a Level of Intervention of any kind. As described below, many were not reviewed within the five day timeframe outlined in this process document. While slightly improved, the documentation of PNMT actions continued to be disjointed	Noncompliance

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		and difficult to follow. In most cases, the minutes stated that an assessment was in process or that there had been discussion, rather than the content, focus, or outcomes of the discussion. Actual referrals were not consistently clearly stated in the meeting minutes. In some cases, perhaps after discussion, individuals were deemed inappropriate for referral or assessment (Individual #512, Individual #44, Individual #16). Lack of follow-up was noted in many cases. For example: • Individual #1: The RD recommended a referral to the PNMT on 6/15/12 due to being chronically underweight. The minutes indicated that the team would gather information to determine if he "qualified" for an assessment. There was no evidence of a follow-up or resolution as of 9/21/12. A PNMT meeting was observed by the monitoring team. This meeting was led by the chairperson and was disjointed in topics and discussion flow. She had a pile of papers in front of her that were supposed to be referrals that they were to review. There was no agenda and there was no discussion of the current individuals followed by the team other than to respond to questions by the monitoring team. Copies of the referrals discussed were requested and included: • Individual #427 (wheelchair), date of request 8/15/12, referral received on 8/17/12. • Individual #528 (suction toothbrushing), date of request 9/6/12, referral received on 9/11/12. • Individual #314 (suction toothbrushing), date of request 9/11/22, referral received on 9/11/12. • Individual #525 (PNMT evaluation), date of third request 9/12/12. The request from the QDDP documented that, during his ISP, the IDT determined that he should be referred to the PNMT for failure to thrive. His ISP had been held on 2/7/12. Per the PNMT chairperson, she had returned the request because they had not properly completed the referral and had not included the information required. It was of great concern to the monitoring team that these referrals had not been addressed in a timely manner. It was of further concern that the referral for Individual #525 was not addressed due to a paperwork issue. Clearly the director/chairperson of the PNMT did not have an appreciation of the need for swift and timely action for individuals identified at greatest risk for significant health concerns. There were no thresholds for intervention developed. There were guidelines for the PNMT to review referrals, but these were clearly not adhered to. There were no guidelines to direct the timeframes for completion of assessments or other actions.	

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		PNMT Assessment and Review There were no completed Comprehensive PNMT Assessments submitted within the last two months, as requested. On 7/27/12, it was stated in the minutes that assessments for Individual #533, Individual #151, Individual #341, and Individual #188 were completed and pending approval by the PNMT director. The referral dates for these were 2/7/12 for Individual #533, Individual #151, and Individual #188, and 3/26/12 for Individual #341. The drafts of these reports were requested. It was noted that in each case, the assessment contained data, but the analysis of findings, recommendations, measurable outcomes, monitoring schedule, and criteria for discharge were incomplete. The process for completion and review was not outlined in a policy, but all team members, including the chairperson, were listed as core team members and all signed the completed assessments. As such, all team members had a responsibility to complete these in a timely manner and in the case a team member was not fulfilling his or her responsibilities, it would be the chairperson, the habilitation therapies director as supervisor of all team members, to intervene and remedy the issue and ensure that the assessments were completed appropriately and competently. With identified needs justifying an assessment by the PNMT, there is then an urgency to complete the assessment and implement appropriate interventions to address the identified needs. These should be completed in 30 days, at most. It is critical that these assessments be completed timely because these individuals were had significant need for supports and services to address identified PNM health concerns. None of the assessment drafts were completed, so it was not possible to analyze these for quality because many key elements were missing. The clinical analysis of findings and recommendations were not known as a result. There were no clinical indicators defined, such as established thresholds, baselines, or clinical criteria. There was no audit tool developed and no content guidelines for assessment completion. There were only two PNMT assessments completed in the last six months available for review by the monitoring team: • Individual #38: Meeting minutes did not reflect any review of his status while he was hospitalized in February 2012, though his PNMT assessment was in process at that time. The first notation in the IPNs (3/26/12) was by the SLP related to attempting an oral motor assessment. On 3/19/12, an inservice was done by the OT, related to suction toothbrushing. It was stated that a full report was to follow in the PNMT assessment. There were subsequent IPNs related to toothbrushing and head of bed elevation evaluation only through 5/30/12. On 6/1/12, a note in the IPNs indicated that the PNMT was in the process of completing his assessment. The recommendations included the following per an IPN dated 6/15/12:	

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		o Medications should be consistent across all forms (MD orders, MAR, IRR, and Action Plans) o Suction toothbrushing to be implemented by habilitation therapy staff o Head of bed to be elevated at 30 degrees at all times except bathing and check/change, when it could be 20 degrees. o Revise PNMP in all areas, though the report stated that these were related to wording and arrangement, rather than for substantive supports and interventions. o Consider high risk ratings for cardiac disease and circulatory. In the opinion of the monitoring team, these were minor actions given the extended time period (over four months) taken to complete this evaluation. • Individual #72: The referral dated for the PNMT assessment was 11/21/11, yet it was not completed for more than five months. While there were more recommendations outlined in his report, very few were substantive changes to his existing supports to address his identified PNM needs. The concern for this lack of urgency was highlighted during the previous review by the monitoring team. Clearly, MSSLC did not heed this concern because it was an even greater problem now than at that time. <u>Risk Assessment</u> Risk rating tools and/or action plans were submitted for the 19 of 23 individuals (83%) in the sample for whom individual records were requested. These tools were to be completed by the IDT at the time of the annual ISP with routine review after hospitalizations or other changes in status. An action plan was developed to manage or mitigate identified risks. For the most part, risk ratings and the rationales provided improved since the previous review. The teams appeared to do a better job of considering other issues that may predispose an individual to special health concerns. The most common problem was the assignment of low risk for conditions, such as cardiac disease or diabetes, without consideration of family history for these. Some examples are below. There were additional potential inconsistencies with regard to risk assessment and actual occurrences of health issues. Some examples included: • Individual #446 had a choking incident on 10/28/11, but was listed only at LOW risk for choking. • Individual #197 was listed with a BMI of 17.2, which is in the underweight category, yet he was identified at LOW risk for weight. • Individual #436 was listed with a BMI of 16.6, which is in the underweight	

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		category, yet he was identified at MEDIUM risk for weight. • Individual #209, Individual #123, Individual #192, Individual #215, Individual #432, Individual #426, and Individual #355 were listed with BMIs in the obese range (30 or greater) and were identified at LOW risk for weight. • Individual #367, Individual #294, Individual #571, and Individual #238 were listed with BMIs in the morbidly obese range (40 or greater) and were identified at MEDIUM risk for weight. • Individual #195 and Individual #47 were listed with an unplanned weight loss of 10% or more in a six month period, yet were identified at LOW risk for weight. • A number of individuals were listed with two fractures in the last 12 months, yet were identified at LOW risk for fractures (Individual #69, Individual #15, Individual #33, and Individual #300).	
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> It was reported that 271 individuals at MSSLC had identified PNM needs and, as such, should be provided PNMPs (73% of the census). Comments below relate only to the PNMPs submitted for the individuals in the sample (23). Improvements in the format and content were noted. Additional improvements in the implementation of the plans since the last onsite review were also observed. • PNMPs for 23 of 23 individuals in the sample (100%) were current within the last 12 months. • PNMPs for 21of 23 individuals in the sample (91%) were of the same format and consistent with the most current state-established format that included risk levels, triggers, and outcomes. • PNMPs for 23 of 23 individuals in the sample (100%) included a list of risk areas. There was no indication if these were high, medium or low risk areas. There was no rationale listed for these. Some of the triggers listed were clearly associated with a specific risk area, others were just listed. • In 0 of 23 PNMPs (0%), were there pictures other than of the individual. Several plans referenced picture pages, but none were submitted with the request for PNMPs. These should be considered a key element of the plans and, if available, should always be associated with a plan. If they are not available, these should be developed to provide additional supports and references for staff use to appropriately implement these plans. • In 23 of 23 PNMPs (100%), positioning was addressed. • In 16 of 16 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, some positioning instructions for the wheelchair were included, though this was generally very minimal. • In 23 of 23 PNMPs (100%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without	Noncompliance

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		assistance. • In 23 of 23 PNMPs (0%), the PNMP had a distinct heading for bathing instructions. The bathing equipment was listed with staff assistance needed as indicated. • In 17 of 23 (74%) of the PNMPs, toileting-related instructions were provided. • In 16 of 16 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning or the individual was listed as independent. • In 23 of 23 PNMPs (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. Each also had a Dining Plan current within the last 12 months at the time of this review • There were 11 of 23 individuals who had feeding tubes. Seven of these PNMPs indicated nothing by mouth or specified fluids by mouth as indicated for Individual #257 (64%). Four others indicated only that the individual received enteral nutrition. • In 0 of 23 PNMPs (0%), dining position for meals or enteral nutrition was provided via photographs. • In 12 of 12 PNMPs (100%) for individuals who ate orally, diet orders for food texture were included. • In 12 of 12 PNMPs for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 12 of the 12 PNMPs for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section. Five individuals had no equipment listed and the plan did not specify that regular utensils were used (Individual #281, Individual #436, Individual #477, Individual #291, and Individual #587). Specification, although not required, is suggested to help staff know exactly what is expected. In the case of Individual #281, his picture showed a divided plate, but this was not listed on his plan. • In 23 of 23 PNMPs (100%), a heading for medication administration was included in the plan. This included positioning and preparation instructions for 10 of 11 individuals with a feeding tube. There were no positioning instructions provided for Individual #341. For those who received oral medication, form or preparation was outlined, but positioning was not. For six of 13 individuals who received oral medications, adaptive equipment was specified. It was not known if this was omitted from the others or that they did not require adaptive equipment. If that was the case, this should specify that none was needed when indicated. • In 14 of 23 PNMPs (61%), oral hygiene, including brushing instructions and position, was addressed. The others did not specify the position. • 23 of 23 PNMPs (100%) included information related to communication. Six of these did not describe how the individual communicated, but rather referenced	

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		use of the Communication Dictionary. None provided strategies for staff as a communication partner. The strategies included in the communication assessment should be included here for easy staff reference. Only one referred to AAC use. A formal plan for auditing the PNMPs had not yet been implemented to ensure that all content areas were included and to ensure consistency of content. <u>Integration of the PNMPs in the ISPs/ISPAs</u> There were 23 ISPs submitted for the 23 individuals included in the sample selected by the monitoring team. Each was current within the last 12 months and signature sheets were included for all. ISP meeting attendance by the following team members was as follows for the current ISPs included in the sample were present in the individual record, though there were generally other team members in attendance (also see section F): • Medical: 4% (1/23) • Psychiatry: 9% (2/23) • Nursing: 91% (21/23) • RD: 35% (8/23) • Physical Therapy: 61% (14/23) • Communication: 48% (11/23) • Occupational Therapy: 39% (9/23) • Psychology: 61% (14/23) • Dental: 0% (0/23) It is not 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 cannot be reviewed and revised in a comprehensive manner by the IDTs. The Physical Nutritional Management Plan was referenced in 21 of the 23 current ISPs (91%). The content varied greatly, though the newer format ISPs stated specifically that the IDT had reviewed the PNMP. Not all ISPs specifically stated whether the strategies in the plan continued to be appropriate. In most cases, this section appeared to address the language or written instructions in the plan rather than specifically addressing how well they worked for the individual or the rationale behind them. In most cases, specific strategies were not included and few listed any required changes. Some examples included: • Individual #140: The ISP merely stated that the IDT reviewed, updated, and	

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		approved the revised PNMP, but did not offer any specific strategies or changes. • Individual #436: The ISP stated that he did not have a PNMP, but that one would be developed for his eyeglasses. There was no need to develop a PNMP for eyeglasses if there were no other PNM strategies indicated for him. • Individual #432: The PNMP was referenced with some changes and then the entire OT/PT assessment was embedded in the ISP. This was cumbersome and unnecessary. This was also noted for Individual #120, among others. • Individual #197: The ISP stated that the PNMP was reviewed by the evaluating therapy team and that no changes were recommended. This process should be an IDT process. While the therapy team may come with some recommendations, the actual review and the identification of changes needed should be conducted by the entire IDT. • Individual #587: The PNMP was referenced only in relation to her numerous falls over the last year and did not clearly identify the strategies in place or changes made to address this concern. None reflected a substantial discussion and review of the efficacy of the strategies included in the plan, but generally was an improvement in this area since the previous review by the monitoring team. Guidelines should be identified to ensure consistency across ISPs and to assist the QDDPs in meeting this standard in their facilitation of ISP meetings and subsequent documentation of PNMP review and approval. Continued training for QDDPs was indicated to ensure an appropriate description of the annual and quarterly reviews of the PNMP.	
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 variable input by other IDT members. Attendance by PNM-related professionals at the ISP meetings was limited and, as such, discussion and input were limited. There was limited evidence of ISPAs for required changes in the PNMPs. In the sample reviewed, ISPAs for only 10 of 23 individuals referenced a review of the PNMP in at least one or more of the meetings. Continued efforts to increase attendance at the ISPs and ISPAs, and continued participation of other team members in this process, should improve IDT involvement in the development of the plans. The PNMP should be reviewed in most ISPs to determine if any of the outcomes would require a change to the plan. 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 individual-specific in the PNMPs. General practice guidelines with regard to transfers, position and alignment of the pelvis, and consistent use of foot rests and seat belts were	Noncompliance

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		taught in NEO and in individual-specific training provided by the therapists and PNMPCs. Observations There was continued improvement related to mealtimes in the homes observed by the monitoring team. There were only a few notable concerns related to implementation; these are presented below: • Individual #140: He was seated with two other men at a small table because the other available table recently acquired was too low to accommodate his wheelchair. • Individual #60: He put his mouth to the plate and shoveled food in with no supervision or intervention. His Dining Plan indicated that staff should encourage him to sit up. • Individual #456: The PNMPC assisting him was standing rather than seated at eye level. • Individual #281: He was being assisted to eat too rapidly by staff. He was observed to cough numerous times throughout the meal, but staff did not stop or call the nurse until prompted by the monitoring team. Staff reported that he had an aspiration trigger sheet, but that he always coughed at meals. There was no aspiration trigger sheet in his notebook. The risk assessment in his individual notebook was dated 8/11/11. His ISP was also dated 8/11/11 and both were not current. The risk ratings were manually crossed out and new risk ratings were added and dated 3/9/12. He was listed at low risk for aspiration. • Individual #96: He was observed overloading his spoon, but staff reported that they could only give verbal prompts due to his behavior. They reported that they could provide physical prompts only to limit his use of salt. He was at risk for choking; this should be addressed collaboratively by habilitation and psychology. • There were not enough serving spoons in the Barnett dining area and a number of individuals (Individual #31, for example) had to wait with bowls of food sitting on their table. The food was allowed to cool there for more than 10 minutes. The kitchen staff had to call the main kitchen to bring additional spoons. Other trays of food were waiting on the serving line due to the lack of spoons. • Individual #376: Staff were assisting her to drink. Her Dining Plan stated that staff should provide cues to return the cup to the table. When prompted staff allowed her to drink independently from the cup, but then took it away from her rather than providing the appropriate prompt. Positioning and alignment were also improved. Some examples of concerns were: • Individual #311: He was slumped down in his chair throughout the meal. Staff did not cue or assist him to sit up. • Individual #25: He was seated in his wheelchair and pushed up to the piano. The	

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		staff did not notice that his knees were pressed against the sharp edge of the piano and was prompted by the monitoring team to move him. There were deep indentions on both knees, three on his left and one on the right. Staff reported that he rocked in his wheelchair. • Individual #525: He was supposed to sit in a regular dining chair for meals, but he was seated in a transport wheelchair waiting to be served and assisted. • Individual #427: He was slumped down in his wheelchair; his head was off to the left and under his headrest. The wheelchair in his plan was not the same as the one he was seated in. The PNMP was dated February 2012. Per the DSP he had been returned to his old wheelchair a month or more ago. The PNMP did not reflect this change. The majority of staff struggled to verbalize the rationale for the strategies in the plans and to answer questions related to individual health risks, but there were some others who demonstrated excellence with regard to this. <u>Choking/Aspiration Events</u> There were two choking incidents since the previous review (Individual #390, 3/1/12 and Individual #587, 6/10/12). Abdominal thrust was required in the second case in which she had taken another individual's food. On 6/12/12, the SLP completed a consult that addressed only the food stealing issue and there was no evidence of a mealtime observation to ensure that the Dining Plan continued to be effective or that there were no swallowing issues secondary to the choking incident. This evaluation should have been completed prior to the next meal after the choking event. Though listed with a choking incident and documentation was requested, none was submitted for Individual #390.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>New Employee Orientation</u> The NEO training included three hours dedicated to lifting, transfers, and positioning/re-positioning. Competency check-offs were included for the stand pivot transfer, two person manual lift, mechanical lift and there was a written test. There was no specific competency for positioning noted. PNMPs and Dining Plans were covered in a two hour session with only a written test. There was no evidence of a skills-based competency for this portion of the training. There were no materials submitted that addressed food textures or liquid consistencies and, as such, there were no competencies related to these key elements. Food textures, liquid consistencies, and dysphagia were previously covered in a four hour session that also addressed communication and AAC. There were no curriculum materials related to this and the schedule indicated that AAC was addressed in a single one hour session only.	Noncompliance

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		Habilitation programs and eating were covered in one hour and a half and physical management was addressed in another two hour session. A mealtime practicum was listed on the schedule, but no materials were submitted related to this. Task analysis reference lists were in 13 areas, but these did not have check-off documentation and it was not clear how they were utilized for training purposes. Many of the items appeared to be elements related to monitoring ("Is the equipment clean?") rather than staff knowledge and skills. In the Adaptive Equipment reference list, there was general question regarding whether the staff knew how to implement, utilize, and care for the equipment, but was not broken down into specific competencies to determine this. Extensive materials were submitted for staff training related to Orientation and Mobility that was recently added to the teaching responsibilities of the OTs. This was a one hour and 15 minute training session, which seemed excessive compared to the other PNM concerns. In addition there was another one hour and 15 minute session devoted to deaf awareness also taught by habilitation staff. It would seem necessary to identify the number of individuals who required actual orientation and mobility assistance due to visual impairment and also the number of individuals with hearing impairment to determine if this amount of time allotted to these areas was appropriate. It appeared that actual training time devoted to communication was extremely limited at one hour and this should be much more because it impacted the supports provided to everyone living at MSSLC. 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. <u>Individual-Specific PNMP Training</u> Inservice training for changes in the Dining Plans and PNMPs were conducted by therapists and by 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 listed questions that could be answered verbally 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 he or she 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. In cases of supports that fell outside the typical realm of transfers, positioning, and mobility, there was no clear method to ensure that all staff were trained.	

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		For example, Individual #80 was provided a chewy device to address finger mouthing. This was on her PNMP under Behavior Concerns, but not in her PBSP. The staff demonstrated that even when assisted to hold it, she put her fingers in her mouth only. It was attached to her headrest because she could not place it within reach as it would fall on to the wheels of her wheelchair and get dirty. The plan stated it should be attached to her clothing, but there was no way to do this. Staff reported that she had not been trained related to this device. There was an activity plan in the individual notebook for monitoring this, but there was no documentation that this had occurred. These plans should not merely verify that the equipment was present, but was also used correctly by staff and continued to be an effective support that met the needs of the individual. MSSLC had not clearly established which plans contained only foundational skills for which competency had been established in NEO (or refresher training) versus those with more specialized techniques (non-foundational) that required additional competency training and check-offs. If a change in plan was minor, an inservice could be provided without check-off, but these differences should be clearly stated. If further staff training was required, the therapists should establish competency of the PNMPC and/or home supervisors who could complete cascade training for the additional staff. This process will be a focus of future reviews by the monitoring team. It is important that staff were not to work with an individual at high risk until they had been trained and checked off. Pulled staff should receive this training by supervisors, managers and/or habilitation therapies as necessary. Training for pulled staff should not be limited to merely reading the plans. There did not appear to be a clear protocol related to ensuring that training for pulled staff was provided in a timely manner. Many of the staff observed by the monitoring team reported to have been pulled staff and most were not able to state that they had received specific training related to the individuals to whom they were assigned regarding PNM supports and risk issues. Many seemed to use the fact that they were pulled staff as an excuse for not knowing specific information about the individuals they were assisting. One such staff was assigned to be a one-to-one staff with Individual #293. She did not know his risks and did not know how to address his coughing. He was observed to cough excessively by the monitoring team. She did know to check his wrist restraints every 30 minutes and to release them every hour for 15 minutes. His PBSP dated 11/17/11 said that staff should engage him in sensory stimulation, but specifics of the process to address his restraints were not described anywhere in his individual notebook. <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-	

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		based, though the sign-in sheets suggested that training was not skills-based, but rather competency was established via a verbal quiz. 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. In fact, it was reported that, because they were not able to conduct monitoring tasks effectively, they had been reassigned to the therapists for training and would begin to conduct more training of staff rather than monitoring. A curriculum was reported by the director to still be in process at the time of this onsite review as had also been the case during the previous review as well. There were no specific outcomes or competencies established to guide the therapists to ensure that all PNMPCs received similar training. It appeared that many of the PNMPCs were confused as to their current role and were often used as therapy technicians or aides. It was not likely that, without specific competency-based training, the PNMPCs would be able to successfully provide staff training. Formalized training to prepare these staff for whatever role to which they were assigned continued to be an urgent need.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>Individual-Specific Monitoring</u> The current monitoring system for implementation compliance and staff competency was to be based on individual risk levels. While this type of monitoring focused on staff performance, it was tracked per individual rather than per staff. As such, it was not possible to ensure that all staff were monitored for continued and consistent compliance. This was different than monitoring that focuses on the individual's health status and the impact of supports and services on health, function, and risk levels and that should be a key element in an effective PNM system. Thus, there was a need for greater focus on individual status monitoring and review of triggers, in addition to staff compliance monitoring. There was no clear system of monitoring individual status routinely and effectively. Compliance monitoring data were not utilized consistently during the ISP meetings, PNMT meetings, or in the therapy assessments. Recommendations related to the frequency of monitoring pertained only to the Activity Plan monitoring described below. The potential links between the individual status monitoring and staff compliance monitoring should be identified via routine trend analysis. There was little evidence of this type of review conducted by habilitation therapies. The list of individuals for whom PNM monitoring had been completed in the last quarter was requested and submitted. These lists identified that approximately 260 monitorings were completed in June 2012 compared to only 29 in July 2012 and 17 in August 2012. It was likely that the PNMPCs had conducted most of those completed in June 2012 and the numbers then dropped off dramatically when they were pulled from that duty to shadow the therapists. The list was organized by date, rather than by person, so it was not	Noncompliance

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		possible to determine how many individuals were at high risk and if the frequency of monitoring for those individuals was greater. The monitoring team attended Individual #151's ISP and it was evident that he presented with many HIGH risk health indicators that warranted an increased frequency of monitoring. He was monitored one time in June 2012 and then none in July 2012 or August 2012. There were likely many others like this. The monitoring team also requested monitoring forms completed by OTs and PTs in the last month, and forms completed in the last three months for the 23 individuals in the sample. These two requests were combined for review and analysis. Two forms were duplicated in both requests. Only 27 forms were submitted for 17 individuals. A statement that no monitoring had been provided in the last three months was submitted for 14 of the individuals. The majority of these were completed by therapy staff. This number was inadequate to effectively evaluate trends or issues related to staff competency or compliance. A compliance score was not calculated for any monitoring form completed. For 18 forms, all items were marked "yes" if considered applicable and, as such, would be scored 100%. A total of 33% of the completed forms identified one or more concerns as indicated by a "no" answer. The activities monitored were as follows: • Mobility (1/27, 4%) • Transfers (9/27, 33%) • Communication (0/27, 0%) • Mealtime (3/27, 11%) • Oral Hygiene (0/27, 0%) • Medication Administration (1/27, 4%) • Positioning (2/27, 7%) • Adaptive Equipment (7/27, 26%) • Bathing (4/27, 15%) • Behavior (0/27, 0%) There was no monitoring conducted on third shift, 67% were conducted on second shift, and 33% on first shift. Monitoring was conducted as follows: • June = 5 • July = 2 • August = 20 While there was an obvious bias for those completed in August 2012 due to the request, there was a significant poverty of monitoring completed for the individuals in June 2012 and July 2012. Eight of the individuals monitored were listed at high risk for specific PNM-related concerns and four of those were monitored only one time in August 2012.	

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		The others were monitored more often, but over a three month period as follows: Individual #477 (2), Individual #120 (2), and Individual #341 (2). Individual #524 was monitored four times in two days by the same PT, but with four different staff related to bathing only. It was of grave concern that there essentially was no effective system of routine monitoring for staff compliance or individual –specific review of the PNMP supports.	
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>Effectiveness Monitoring</u> There was no evidence of routine effectiveness monitoring of the PNMPs and dining plans by the professional staff. Consideration for how this could be addressed was needed. The universal form used for PNMP monitoring did not have an option for the clinical therapist monitor to mark if the plan was effective or ineffective. In short, it appeared that no effectiveness monitoring occurred beyond the annual assessments or in response to identified problems/referrals. There was no proactive review. The system of Activity Plans was intended to direct the clinicians to conduct quarterly reviews of basic plans for DSP staff to walk with the individual, for example, or to check on adaptive equipment, such as splints, wheelchairs, and walkers. These were numerous and in fact counted as a direct support. Many of the plans pertaining to equipment merely addressed the availability of the equipment and its condition, rather than the effectiveness of the equipment (Individual #533, Individual #1, and Individual #38, for example). In the assessments reviewed, equipment and supports were described, but often stopped short of actually assessing or analyzing the impact on function, health, or risk levels. In many cases, the effectiveness of interventions and supports were not consistently and specifically addressed in the annual assessments. This should be a key function of the professional staff clinicians. This should be incorporated into routine quarterly/monthly reviews. Findings should be included in the IPNs rather than on a separate form filed in the habilitation therapies section of the individual record. Similarly, this kind of analysis should be incorporated into routine, consistent documentation of other direct and indirect interventions. Effectiveness monitoring and additional staff training was indicated related to implementation of programs across all environments. <u>Validation of Monitoring by PNMPCs</u> There is no possible way that paraprofessional staff can meet the expectations for appropriate and effective monitoring, coaching, or staff training without clearly defined expectations, and competency-based learning objectives and activities in a formalized curriculum to specifically teach them their roles and responsibilities .	Noncompliance

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		Trend Analysis There was no evidence of trending or tracking of the monitoring data submitted for review.	
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 were32 individuals who received enteral nutrition, three of which were gastrostomy/jejunostomy tubes. Only Individual #341 was listed as having received a new tube placement since the previous review. Individual #440, Individual #196, and Individual #257 were listed as receiving pleasure feedings of some type, though not specified. All others were NPO (nothing by mouth). Four individuals who received enteral nutrition were also listed with poor oral hygiene (Individual #196, Individual #266, Individual #306, and Individual #407). The list that identified individuals with pneumonia in the last 12 months included 41 incidences for 28 individuals from 9/1/11 to 8/20/12. Twelve of those individuals received enteral nutrition and the others were reported to eat orally. Seven of these individuals had more than one incidence of pneumonia. Three had pneumonia two times (Individual #533, Individual #273, Individual #188), three were listed with pneumonia three times (Individual #542, Individual #341, Individual #72), and one individual had pneumonia five times (Individual #151) in the last year. There were at least six cases of aspiration pneumonia for five individuals. Three of these were listed with more than one incidence of pneumonia (Individual #542, Individual #72) and Individual #151 was listed with two incidences. The others had incidences of pneumonia categorized as other than aspiration related. Each of these individuals had been evaluated by the PNMT, but only Individual #72 had a completed written report. It was of significant note and great concern that his assessment was not completed until 4/16/12, though the referral documented in the report was on 11/21/12 following a hospitalization for aspiration pneumonia. Each of these individuals presented with urgent, significant, and complex health issues that would potentially benefit from the expertise of a PNMT. The PNMT at MSSLC had not met the needs of these individuals in a timely manner. There were seven APEN assessments submitted for review as completed in the last six months. Per policy, these were to be completed for individuals with aspiration pneumonia in the last year and/or individuals who received enteral nutrition. While it was positive that these assessments were completed, most did not provide a sufficient rationale for continued enteral tube use or clearly present the rationale for the	Noncompliance

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		interventions and supports provided. The monitoring team does not specifically challenge that any of these individuals should not have a tube or receive enteral intake, but improvements in documenting the rationale for this were needed. There were three individuals who had been assessed for oral intake and were currently provided pleasure feedings. This was a positive finding and review of these individuals will be a focus for subsequent reviews. At least six individuals had been assessed and were engaged in a suction toothbrushing program. While this was initiated by habilitation therapies, it was reportedly being transferred to nursing. As stated above, the PNMT had received at least four referrals for evaluation, but these had not yet been completed at the time of this review. The most outstanding of these was for Individual #151, since June 2012, who as stated throughout this report, was at significant risk and had not been provided a completed PNMT assessment in over seven months' time. It was reported in the self-assessment that of the APENs required for individuals at MSSLC, only 30% had been completed. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP and Dining Plan that included the same elements as described above.	

Recommendations:

1. Completed PNMT Assessments in 30 days (O1).
2. Revise the Settlement Agreement Audit Tool to reflect meaningful indicators for self-assessment (O1–O8).
3. Establish effective leadership for PNMT facilitation. This did not need to be the Department Director but rather a core team member such as a full time nurse. The other PNMT members did not necessarily have to be full time dedicated members. The hospital liaison should not be a replacement nurse on the team. This position should be filled by a full time nurse as soon as possible (O1).
4. Continue to review and refine PNMT meeting process, meeting documentation and documentation for individuals reviewed by the team to ensure it is thorough yet concise and useful to the full IDT (O1 and O2).
5. Consider projection system for computer to permit all present at PNMT meetings to see documentation in real time (O1).
6. Review system of follow-up for individuals reviewed by the team (O2).
7. Develop operational policy to reflect process of referral, assessment, review and follow-up (O1).

8. Take steps to better integrate the PNMT Action Plan with the IDT plan. Ideally this should be a single plan developed in collaboration with both teams (O2).

9. Collaborate on implementation of guidelines to incorporate pertinent findings and improve PNMT analysis of findings and recommendations (O2).

10. Report monitoring data in assessments and use this information during meetings to better evaluate the effectiveness of interventions, supports and plans, as well as staff competency and compliance (O7).

11. Implement PNMP audit process (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 MSSLC client list o Admissions list o Budgeted, Filled and Unfilled Positions 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 PET Monthly Worksheet o Individuals with PNM Needs o Dining Plan Template o PNMP template o PNMP Monitoring template o PNMP Monitor the Monitor template o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Completed PNMP Monitoring forms submitted o List of PNMP monitoring completed in the last quarter o Hospitalizations for the Past Year o Summary List of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o List of Individuals with Aspiration and/or Pneumonia o List of Pneumonias in the Past Year o Individuals with Pain o Individuals with Choking Incidents and related documentation (Individual #171 o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals Having Falls Past 12 Months List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o Skin Integrity Spreadsheet o Individuals with Fractures Past 12 Months

	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 Individuals with Orthotics or Braces o PNMPs submitted o Competency-based training documentation submitted o PNM Maintenance Log o Wheelchair evaluations submitted o Adaptive Equipment Spreadsheet o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template o OT/PT Assessment Spreadsheet o OT/PT Assessments for individuals recently admitted to MSSLC: Individual #838, Individual #754, Individual #873, Individual #927, and Individual #700. o OT/PT Assessments and ISPs for the following individuals: Individual #210, Individual #442, Individual #61, Individual #196, Individual #242, Individual #457, Individual #446, Individual #128, Individual #35, Individual #328, Individual #26, Individual #266, Individual #521, and Individual #489 o OT/PT Assessments, ISPs, ISPAs, and other related documentation for the following individuals: • Individual #518, Individual #84, Individual #549, Individual #303, Individual #16, Individual #353, Individual #449, Individual #557, Individual #570, Individual #160, Individual #185, Individual #175, Individual #321, Individual #40, Individual #390, Individual #455, and Individual #225. 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #432, Individual #533, Individual #281, Individual #140, Individual #120, Individual #369, Individual #178, Individual #197, Individual #435, Individual #341, Individual #436, Individual #72, Individual #38, Individual #226, Individual #188, Individual #427, and Individual #291, Individual #477, Individual #151, Individual #391, Individual #257, and Individual #1. o PNMP section in Individual Notebooks for the following: • Individual #432, Individual #533, Individual #281, Individual #140, Individual #120, Individual #369, Individual #178, Individual #197, Individual #435, Individual #341, Individual #436, Individual #72, Individual #38, Individual #226, Individual #188, Individual #427, and Individual #291, Individual #477, Individual #151, Individual #391,

	Individual #257, and Individual #1. o Dining Plans for last 12 months, PNMPs for last 12 months, Aspiration Trigger Sheets for the following: • Individual #432, Individual #533, Individual #281, Individual #140, Individual #120, Individual #369, Individual #178, Individual #197, Individual #435, Individual #341, Individual #436, Individual #72, Individual #38, Individual #226, Individual #188, Individual #427, and Individual #291, Individual #477, Individual #151, Individual #391, Individual #257, and Individual #1. <u>Interviews and Meetings Held</u>: o Brandie Howell, OTR Habilitation Therapies Director o Sandra Opersteny, PT o Harvey Evans, OTD, OTR o Lisa Finley, COTA o Karen Fleming. COTA o Various supervisors and direct support staff o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs and work areas
	Facility Self-Assessment: Based on review of the self-assessment, Brandie Howell, OTR, the Habilitation Therapies Director, attempted to outline specific assessment activities. In many cases, however, these would not lead the facility to achieve substantial compliance with this provision. There were no measurable outcomes established. One finding was that 51 assessments, 80 updates, and 199 consults were completed. The director concluded that there were no outstanding assessments and, therefore, the provision item was 100% in compliance. But, there was no analysis of the timeliness or quality of those assessments. In her presentation for the monthly PET meeting, additional information was given. For example, she reported that 21 individuals were identified as having PNMP needs during that month. This finding did not have any meaning or context and, as such, was not useful in any way. She reported that 146 individuals received OT services and 133 individuals received PT services, yet there were 254 activity plans provided and only 15 treatments and 10 programs. This would lead others to believe that there were extensive supports provided to a large number of individuals. In fact, these activity plans had been developed to provide a documentation format for the therapists to conduct quarterly monitoring. The vast majority of these plans were to monitor adaptive equipment only. The Presentation Book provided a plethora of documents that did not relate to the action plan or self-assessment activities. There was no effective analysis of the findings, accomplishments, and work products. While the existing audit tool was referenced, this was not heavily relied on for self-assessment. This,

	however, was a positive step. While some elements of the tool may be valuable in assessing compliance with this provision, others clearly were not and, as recommended during previous reviews, this tool should be revised to better reflect what is meaningful. All but one of the elements were reported as 100% and, as such, did not drill down what was needed to further assess areas that needed improvement. The activities for self-assessment listed for each provision were numerous and will not be listed here. The findings were presented in narrative form. It would be useful to supplement that with data in a graph or table format to illustrate change and improvements. An action plan to address identified issues should illustrate how Ms. Howell would intend to proceed toward compliance. The facility self-rated itself as in substantial compliance with P1 and noncompliant with three elements of P (P2 through P4). While some actions taken were steps in the direction of substantial compliance, the monitoring team found that all elements were not in compliance. There had been little change in the status for this provision during the last six months.
	Summary of Monitor's Assessment: Minimal progress was made related to this provision. The level of staffing for OT and PT clinicians had decreased and was low for the number of individuals with identified needs. The OT and PT clinicians conducted their annual assessments together. 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. Assessments were reviewed, and consistency for content was found to be unchanged since the last review. The format was not consistently followed and the content for each of the areas assessed varied greatly. There was little analysis of findings and the summary section lacked in the presentation of the clinical reasoning used by the therapists for the development of interventions and supports. There was no clear link to the mitigation of identified health risks and health or medical status over the last year in annual assessments. Findings of monitoring were not reported in the assessments. There was no formal audit of the assessments, no written content guidelines and no evidence of training for the clinicians to ensure competency. There were a small number of interventions provided by the clinicians and a small number of SAPs as well. Documentation, however, was inconsistent and there was insufficient rationale provided to continue or discharge from services. These interventions were not well integrated into the ISP process. The department continued to need to move forward towards the implementation of interventions beyond the PNMP. Effectiveness monitoring of all aspects of the supports provided by OT and PT should be occurring regularly throughout the year. These should determine if the supports were appropriate, if they were working, meeting the identified needs and if they were impacting risk. This should also incorporate the findings of the staff compliance monitoring to determine if it was routinely and properly implemented.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	<u>Current Staffing</u> Brandie Howell, OTR continued to serve as the Director for Habilitation Therapies. Some of the OT/PT staffing was consistent with that found during the previous review, though a number of staff members present during the previous review were no longer working at MSSLC and the contract staff continued to rotate in and out of service. There were four physical therapists, Sandra Opersteny, PT, Gloria Miller, PT, Candy Quieng, PT, and Jeffrey Ronquillo, PT. Ms. Opersteny served as the Assistant Director, clinical lead, and was a member of the PNMT. The occupational therapists were Harvey Evans, OTD, OTR, and Sheila Michael, OTR (full-time state employee). Each of these clinicians had been working at the facility for at least the last year or longer. There were two PTAs (Betty Cotton and Linda Harwell) and three COTAs (Lisa Finley, Karen Fleming, and Candice Drews). One contract PT and two OTs and one COTA that had been on staff during the last review were no longer working at MSSLC. One had recently returned after a 13 week break in May 2012 secondary to contract issues. He provided services at San Antonio SSLC. • 12 of 12 (100%) therapy clinicians were verified with current licenses to practice in the State of Texas. There were five vacant positions for occupational therapy and four for physical therapy. There was one OT and one PT technician. There were seven PNMPCs. The census at MSSLC was 371 individuals and 271 of them were listed with PNM needs. It was reported that the ratio for OT was 1:177 and 1:88 for PT, as Ms. Opersteny did not have a specific caseload assignment. It was not clear how these ratios were calculated, but based on the current staffing and census, actual service ratios for the entire census were 1:186 for OT and 1:93 for PT. Considering only those listed with PNM needs, the ratio improved slightly to 1:136 for OT and 1:68 for PT. In either case, these actual ratios were extremely high for OT. While the ratio for PT for those with PNM needs was manageable, PT would likely have acute care issues to address routinely for some additional individuals not routinely requiring PNM supports. <u>Continuing Education</u> 9 of 12 clinicians reported participation in continuing education during the last six months. Topic areas included: • Geriatric Sensory Processing and Fall Prevention (6 hours) • Seating: Bottom to Top and Standing Justified (1.2 CEUs) • Wheelchair, Seating, Mobility and Positioning (3 hours) • Assessment and Treatment of Age-Related Balance Impairment (16 hours) • Transforming Principles into Practice (6.5 hours) • Memory (6 hours)	Noncompliance

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		This was adequate participation for the clinicians who participated. It continued to be important that all clinicians be encouraged to attend annual educational opportunities beyond just those offered by the state to ensure that they continue to expand their knowledge and skills. Participation in ongoing continuing education is critical and should be encouraged throughout the year for all clinicians. New Admissions Twenty-four individuals were listed as admitted to the facility since the last onsite review. Samples of new admission assessments completed since the previous review were requested and five were submitted. Each of the assessments for these individuals was completed within 30 days of admission OT/PT Assessments The state OT/PT assessment format instructions indicated that the assessment should provide a current picture of the individual's status, in terms of functional abilities, health risks, and potential for community placement. The template used at MSSLC was requested, but the speech pathology assessment format was submitted instead. Per the state format guidelines, the assessment findings were to address health conditions and clinical data reflecting the individual's function and guide the provision of supports. Historical data and information gleaned from record review were to be pertinent to the assessment and provide an analysis of relevance to clinical findings and recommendations. Therapists were instructed to analyze the clinical information as each section was completed, so that reasoning was not lost. Skill acquisition and functional activities were to be considered throughout the assessment process. Functional and measurable objectives were to be outlined as indicated. These guidelines indicated that recommendations for supports and activities, other than direct therapy requiring a licensed professional, should be incorporated into the ISP so they may be integrated throughout the individual's daily routine. This was of significant concern to the monitoring team because all aspects of supports and services should be included in the ISP. Per the guidelines, the comprehensive assessment was to be completed within 29 days of admission and an update was to be completed at least annually regarding services provided during the past year. A comprehensive assessment of specific systems and related areas was to occur upon a change in health status. A schedule for re-assessment was to be included in the written report. The content guidelines for each of these areas were extensive and comprehensive in nature. It was not possible to analyze the format used at MSSLC because the format currently used was not submitted. In review, however,	

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		only one assessment included in the analysis below contained each of the standard headings that were noted to be common in the majority of MSSLC assessments submitted. The most frequent omissions were factors for community placement and method of communication. Content varied greatly and the clinicians would benefit from specific guidelines to shape these reports. Per the self-assessment, 51 assessments, 80 updates, and 199 consults were completed from April 2012 through July 2012. It was not known how many were required though it was stated that they were in 100% compliance and there were no outstanding assessments. The five most current assessments for each clinician, new admission assessments (5), and the OT/PT assessments for the 23 individuals in the sample selected by the monitoring team were submitted for review. Only assessments submitted for therapists currently employed at the facility were reviewed (17). Duplicates for Individual #257, Individual #197, and Individual #291 were not included. A current assessment was not submitted for Individual #477. The assessment for Individual #432 was missing pages. ISPs were also requested and submitted for each individual except those who were newly admitted (39). Each was current within the last 12 months. • 37% (16 of 43) were identified as comprehensive assessments. • 12% (5 of 43) were identified as baseline assessments. • 51% (22 of 43) were identified as baseline update assessments. Only comprehensive and baseline assessments (21) were included in the following analysis: • 0 of 21 individuals had comprehensive assessments that contained each of the 23 elements outlined below. • Overall, however the assessments were good for some elements, but were missing some key content. The elements listed below are the minimum basic elements necessary for an adequate comprehensive OT/PT assessment. The current state assessment format and content guidelines generally required that these elements be contained within the assessments. The percentage of assessments (21) that contained each element are listed below: • Signed and dated by the clinician upon completion of the written report (0%). • Dated as completed 10 days prior to the annual ISP (81%). The state required these to be completed 10 working days prior to the ISP per the ISP meeting guide. • Diagnoses and relevance to functional status (10%). • Individual preferences, strengths, interests, likes, and dislikes (43%). • Medical history and relevance to functional status (5%). • Health status over the last year (19%). • Medications and potential side effects relevant to functional status (11%). Some	

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		assessments listed only the purpose of the medications, others provided some potential side effects. It would be useful to report if any of these were experienced by the individual and/or if they impacted function. • Documentation of how the individual's risk levels impact performance of functional skills (25%). It would be important to address all areas of risk relevant to PNM to determine if the current ratings were accurate and if changes were necessary based on findings and to ensure supports and services sufficiently addressed these needs. • Functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day (81%). The quality of the content in this area varied. Many descriptions were more clinical in nature. The more functional the description, the more useful the information would be to the team. • Description of the current seating system for those requiring a wheelchair with a rationale for each component and need for changes to the system outlined as indicated (77%), though the rationale provided in many cases was not adequately specific. • Evidence of observations by OTs and PTs in the individual's natural environments (e.g., day program, home, work) (0%). • Evidence of discussion of the PNMP as well as the effectiveness of the current version of the plan with necessary changes as required for individuals with PNM needs (60%). Many of the assessments reviewed the document, recommending changes in language of the plan rather than discussing the effectiveness of the plan or rationale for actual changes to strategies needed. • Discussion of the <u>expansion</u> of the individual's current abilities (25%). • Discussion of the individual's potential to <u>develop new</u> functional skills (14%). • Comparative analysis of health and impact on functional status over the last year (40%). • Comparative analysis of current functional motor and activities of daily living skills with previous assessments (75%). • Addressed the individual's foundational PNM and functional skill needs including clear clinical justification and rationale (85%). The analyses were largely summaries and lists of what supports the individual should have rather than the clinical reasoning behind them. • Identify need for direct or indirect OT and/or PT services (95%). This was generally more implied than stated. For example, the recommendations generally identified the need to monitor equipment only and it was not typically stated that the individual did not need direct OT or PT. Most individuals were not provided direct services so this would be expected. Recommendations for skill acquisition were infrequent.	

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		• Reassessment schedule (95%). • Monitoring schedule (0%). The only monitoring described was the quarterly monitoring by the clinicians. The frequency of PNMP monitoring was not outlined in any case. • Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs (6%). • Factors for community placement (38%). This section was omitted in a number of assessments. In some cases that it was addressed, the necessary supports and services were not outlined. • Manner in which strategies, interventions, and programs should be utilized throughout the day (100%). This was generally accomplished via the PNMP and mobility skills only. While most of the elements listed above were included in the current state assessment format and guidelines, the clinicians should consider each of these as specific content in the proposed headings to ensure assessments were comprehensive as required by the Settlement Agreement. Additional prompts or cues in the form of guiding questions may be helpful to ensure that key elements are addressed in each assessment. Additional findings: • The assessments rarely identified preferences, likes, and dislikes. These were important for establishing contexts for communication and skill acquisition opportunities, but there was no clear link between these and functional participation in the daily routine. Observations in the natural environments would also provide important clues as to preferences as well as individual potentials for enhancing or expanding existing functional skills. • There were 157 assessments completed from 4/4/12 to 8/23/12. Approximately only 55% of these were completed 10 days prior to the ISP. Fifteen were completed after the ISP (10%), 27 were completed on the day of the ISP (17%), and 28 others were completed less than 10 days prior to the ISP (18%). • It was not known if MSSLC would adopt the Assessment of Current Status format recently developed as an update version of the comprehensive assessment. o It would be appropriate and desirable to conduct this type of modified assessment that was based on the original comprehensive assessment, primarily adding changes in status and the effectiveness of supports and services over the previous year with recommendations for the next year based on a sound rationale, rather than duplicating the extensive format of the comprehensive assessment. o This would permit more time for therapists to focus on the delivery of supports and services rather than on assessment.	

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		○ Of course, a repeat comprehensive assessment would continue to be indicated in cases of a significant change in status and for individuals newly admitted to the facility. • 14% of the assessments contained 0 to five of the 23 minimum elements. • 57% of the assessments contained six to 10 of the 23 minimum elements. • 29% of the assessments contained 11 to 15 of the 23 minimum elements. • 0% of the assessments contained 16 to 20 of the 23 minimum elements. • 0% of the assessments contained more than 18 of the 23 minimum elements. For the ISPs (38): • 100% (38 of 38) of the ISPs submitted were current within the last 12 months. ISPs were not requested for the new admission assessments. One of the current ISPs did not have attached a signature sheet. • 16% (6 of 38) of the current ISPs with signature pages submitted were attended by both OT and PT. • 47% (18 of 38) were attended by PT only. • 8% (3 of 38) were attended by OT only. • 26% (10 of 38) of the current ISPs had no representation by an OT or PT. Formal assessment audits were not completed for editing and teaching purposes to improve the quality. There was no system to establish and ensure continued competency for new and existing clinicians. By report, some of the assessments were reviewed by the habilitation therapies director and/or assistant director. An audit tool should be developed to guide these reviews and to ensure that the same standards are used for each. The elements listed above should be considered for inclusion in the audit tool if not already addressed in the assessment format or guidelines. Training and corrective strategies should be developed as needed to address issues as indicated both for individual clinicians. MSSLC self-rated that they were in substantial compliance with this provision at this time. While there had been some progress in this area, there were too many variables that did not support that. The number of therapists was inadequate, approximately 35% of the assessments were completed in less than 10 days before the ISP, and another 10% were completed after the ISP. Attendance by the therapists was very low and in combination with the lack of assessments available for the ISP meeting, integration with ISP and a reasonable discussion of health risks with the development of a comprehensive plan to address these would not be possible for individuals with PNM needs. In addition the assessments completed contained 65% or less of the elements necessary to ensure that an adequate assessment was provided. There was no formalized system to establish and	

#	Provision	Assessment of Status	Compliance
		maintain competency and no clear method to provide support and training to the clinicians to promote improvement in this area. Therefore, the monitoring team did not find the facility in substantial compliance with this provision.	
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> There were a number of interventions provided beyond the PNMPs, including treatments and programs implemented by OT and/or PT. There was a plethora of activity plans, though these did not typically describe any activity on the part of the individual, but rather a mechanism for the therapists to monitor equipment provided via the PNMP. In some cases, these were documented on Habilitation Therapy SAP forms and filed in the Habilitation Therapies tab of the individual record. As a result, these were difficult for other team members to access or even be aware of. While documentation of interventions was provided, the number of interventions was very limited. The documentation did not consistently meet the basic standards, which are outlined below: • Current OT/PT assessment identifying the need for intervention with rationale. These could be annual assessments or interim assessments completed during the year in response to changes in status or identified needs. • Measurable objectives related to functional individual outcomes included in the ISP. • Routine IPN or other SAP documentation contained information regarding whether the individual showed progress with the stated goal. • Routine IPN or other SAP documentation described the benefit of goal to the individual. • Routine IPN or other SAP documentation reported the consistency of implementation. • Routine IPN or other SAP documentation identified recommendations/revisions to the intervention plan as indicated related to the individual's progress or lack of progress. • Termination of the intervention was well justified and clearly documented in a timely manner. The majority of these did have associated measurable objectives. The documentation, however, did not reflect routine review of status or progress specifically related to the goals, though documentation did appear to be consistently completed. In a number of cases, the justification for changes, holding, or terminating the interventions were not well documented. Some examples are below: • Individual #449: He was seen by PT with long term goals to decrease weight to his ideal weight range (165-190 pounds). There was no evidence of this as an identified need in his annual assessment dated 1/20/12, in his ISP dated 2/12/12, or in any ISPAs since then. A PT treatment plan was submitted with an	Noncompliance

#	Provision	Assessment of Status	Compliance
		implementation date of 2/16/12. He was to be seen in Habilitation Therapy for exercise two times weekly. His baseline weight was not identified in the plan. There was a reference to an injury during therapy in the ISPA dated 5/8/12 and the possible need for an ACL repair in the ISPA dated 6/13/12. A PT was not present at either of these. There was no evidence of a PT assessment. He had complaints of pain on 5/3/12. The plan was amended to include treatment for pain, but did not provide any assessment of the etiology, only that he was to be seen by a doctor. Surgery was scheduled for 6/27/12 for which PT would then be indicated. Documentation of therapy continued through 7/12/12 only, with nothing further and no evidence of a planned discharge. • Individual #557: PT was provided an activity plan for walking using a walker. She was to walk with PNMPC or PTA two times in the morning and two times in the afternoon. Documentation for 7/2/12 to 10/2/12 was unclear because staff used different symbols and it was not possible to determine when she walked or did not. Per the comments, she walked on five occasions only from 7/2/12 through 9/26/12 and more than one attempt on the same day was documented only three times. There was no evidence of review by the PT, though staff documented they would contact him on several occasions. A SAP treatment plan was also implemented on 8/14/12. The goal was to walk inside the parallel bars for 10 laps without hand support. The identified frequency was twice a week for 30 days. She was seen on four days only in a one month period. It could not be determined from the documentation what the plan for continued treatment was. There were two actions in her ISP dated 8/21/12, but neither matched the plans submitted by the PT. • Individual #353: PT was provided to increase left knee range of motion to 0 degrees extension and 120 degrees flexion and to strengthen his left knee extension and flexion. No baseline for either was established. He was to be seen three times a week for six weeks. Therapy was initiated on 1/22/12 and he was seen for one session, there were doctor's orders to discontinue with no rationale on 1/26/12. Therapy was reinstated on 1/27/12 and was subsequently seen on nine occasions in six weeks' time (one refusal by Individual #353 and one no show by Individual #353). Missed sessions were not rescheduled and he was seen and average of one half times per week. Documentation did not reflect progress on specific goals. He was discharged from therapy on 2/29/12 with no statement about progress. Other specifics were not provided and no discharge summary was submitted. Again without assessment or rationale, PT was resumed via a treatment plan initiated on 4/19/12 for PT two times a week for six weeks. Documentation was submitted for 6/19 to 7/19/12 only and reflected two interventions during that time period, with one other cancelled by the therapist (no rescheduled) and one cancelled by Individual #353. Documentation did not reflect progress toward these goals and there was no evidence of	

#	Provision	Assessment of Status	Compliance
		documentation after 7/19/12. There was no assessment related to this intervention and it was not integrated into his ISP or via an ISPA. There was no evidence of a discharge summary. • Individual #16: He was listed with an OT program, but no documentation related to this was submitted. • Individual #518: She was seen for an OT program related to tolerance for suction toothbrushing. The performance criteria to measure tolerance were not stated. This was initiated on 4/2/12, though the frequency was not clear. The long term goal stated four days per week and the short term goal stated two times per week, yet it would be expected that this should be tolerated seven days a week, multiple times each day. From 4/2/12 to 5/1/12, she was seen on 11 occasions, with staff training provided six times, and no intervention provided on eight days due to scheduling conflict. These were not rescheduled and five of these were on consecutive days resulting in nearly 10 days without the intervention. During the next month, further inservice training was provided to staff on three occasions and two cancellations by the OT was documented. The OT reported that on 5/8/12, an ISPA was held to turn this program over to the DSP staff. It was stated that staff had been trained and Individual #518 had met her goals. There was no assessment documented or plan outlined for follow-up and monitoring of this procedure. There was no integration of this program into her ISP or a related ISPA. Documentation of routine supports and services provided was minimal, or very limited, related to acute issues and upon discharge from the hospital for PNM-related concerns as described above. For example, as described above, there was no documented evidence of follow-up for Individual #449 related to his status of left knee pain and/or post-surgical needs for PT.	
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.	<u>Competency-Based Training</u> Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs were addressed in detail in section O above.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	<u>Monitoring</u> 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 PNMP monitoring was not included in the OT/PT assessments. Findings from either type of monitoring were not reported. Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT was included in the PNMP monitoring completed. A log of work orders was generated. The log submitted reflected near monthly review of wheelchairs for January 2012 through April 2012, but there was no evidence of routine maintenance checks after that time. There should be a system of at least quarterly maintenance checks with timely response to requests generated through routine PNMP monitoring, random checks, and reports by direct support and home management staff. The log for modifications and repairs or maintenance should be reviewed routinely by the habilitation therapies director to ensure that these are completed routinely and in a timely manner.	Noncompliance

Recommendations:

1. Continue to recruit experienced OT/PT clinicians to at least maintain or improve staffing ratios (P1).
2. Develop content guidelines for the OT/PT assessments. Consider the state guidelines and those outlined in this report (P1).
3. Implement an assessment audit system to address elements of review applied by the monitoring team (P1 and P4).
4. Clearly establish baselines in the OT/PT assessments as the foundation for interventions and measurable, functional outcomes (P1).
5. Include measurable performance criteria in the objectives for interventions and refer to these in all documentation (P2).
6. Increase consistency of documentation and better integrate it with the IPNs (P2).
7. Explore ways in which attendance at the ISPs/ISPAs can be improved (P1).
8. Include a discussion of the current PNMP and other supports and services provided throughout the last year and effectiveness, including monitoring findings. While each presented a description of supports and services provided over the last year, none incorporated findings from the monitoring conducted related to compliance with implementation and effectiveness monitoring (P1).

9. 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 (P2).

10. Results and findings from PNM monitoring during the last year should consistently be reviewed and summarized (P1).

11. Documentation of direct therapy services should state a clear rationale to initiate, continue the service, modify the plan, or discharge. Measurable 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).

12. The department needs to move forward in the implementation of interventions beyond the PNMP with involvement in the home and day program areas to enhance the meaningfulness and functional activities that meet PNM needs, but also address preferences, interests, and potentials for skill acquisition, engagement and participation in the daily routine (P2).

13. Reconsider the use of activity plans for the purpose of monitoring equipment. They would continue to be useful for those plans that pertain to actual activities engaged in by the individual but not for the purpose of monitoring the condition, use and effectiveness of equipment (P4).

14. Implement a consistent system of quarterly maintenance checks for adaptive equipment, particularly wheelchairs (P4).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o MSSLC Organizational Charts o MSSLC Self -Assessment Section Q o MSSLC Action Plan Section Q o MSSLC Provision Action Plan o MSSLC Dental Operating and Procedure Manual, 7/10/10 o MSSLC Medical/Dental Restraints 1/24/12 o Presentation Book, Section Q o MSSLC Policy and Procedure Home Life and Training Policy #21 Oral Hygiene Care 4/19/12 o MSSLC Organizational Management Manual Committees and Council, Desensitization Committee, 6/1/12 o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Listing, Individuals Receiving Suction Toothbrushing o Dental Clinic Attendance Tracking Data o Oral Hygiene Ratings o Dental Records for the Individuals listed in Section L o Desensitization Plan Progress Note for the following individuals: o Individual #456, Individual #196, Individual #372 Individual #484, o Comprehensive Dental Records for the following individuals: o Individual #169, Individual #17, Individual #105 Individual #455, Individual #491, Individual #469 o Emergency Documentation o Individual #215, Individual #508, Individual #284, Individual #100 Individual #595, Individual #211, Individual #252, Individual #287, Individual #61, Individual #65, Individual #56, Individual #225, Individual #96, Individual #300, Individual #15 Individual #379, Individual #850, Individual #543, Individual #424 Individual #350 o Oral Surgery Consultations o Individual #508, Individual #218, Individual #270 Individual #318, Individual #414, Individual #570, Individual #76, Individual #493, Individual #350, Individual #9, Individual #850, Individual #379 Interviews and Meetings Held: o John Sponenberg, DDS, Dental Director o Jimmy Tompkins, DDS, Staff Dentist o Sandra German, Administrative Assistant o Dolores Erfe, MD, Medical Director

	o Angela Johnson, RN, Medical Compliance Nurse <u>Observations Conducted</u>: o Dental Clinic o Informal observation of oral hygiene regimens in residences o Desensitization Committee Meeting
	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) provision action information. The dental director described, for both provision items, a series of activities engaged in to conduct the self-assessment. For each activity, a result or data point was reported and used to help determine an overall compliance rating. For the most part, the assessment looked at many areas reviewed by the monitoring team. The facility will need to invest time in exploring data accuracy due to the discrepancies noted for many data elements. To take this process forward, the monitoring team recommends that the dental director continue this type of self-assessment, but expand upon it by adding additional metrics that are specific to clinical outcomes in dentistry. The dental peer review should be helpful in determining those metrics. Moreover, it will be important for the self-assessment to comment on all areas reviewed by the monitoring team. The facility rated itself in noncompliance for both provisions. The monitoring team agreed with the facility's self-rating.
	Summary of Monitor's Assessment: The dental clinic made progress during the six months since the previous review. The dental director and administrative assistant were very focused and dedicated to improving services for the individuals. They collected data and had information, which they believed would demonstrate the work done in an effort to move towards substantial compliance. They were, however, not fully confident in the data presented and at one point cited and documented the data as being suspect. The dental database was implemented, but was not fully functional. The facility continued to provide basic dental services onsite, while more advanced services were provided at a local hospital. Many individuals had restorative procedures completed at MSSLC and the staff dentist reported that completing this work took a substantial amount of time for some individuals. Sedation and general anesthesia were not used at MSSLC and there was no plan to do so. The oral hygiene ratings for the facility improved, but many of the records and documents included information indicating that oral care in the homes was not optimal. Training for direct care professionals

	was ongoing. Comprehensive dental assessments were required every six months. Most, but not all, met this timeline. Compliance with the annual requirement was 97%. This was a significant improvement for the facility. The quality of the assessments will need to be addressed. Generally, the content of the dental documentation will need to improve. Documents reviewed often lacked relevant information and forms were incomplete. Failed appointments continued at approximately the same rate of 20%. Discussing missed appointments in the unit meetings did not appear to have any real impact on failed appointments. The dental clinic implemented a new procedure designed to increase accountability with getting individuals to clinic on time. The impact of that procedure was unknown at the time of the review. A new desensitization committee was implemented in June 2012. It reviewed all individuals with a history of refusals and referred the issues to the IDT with recommendations. Most individuals had SAPs developed to address barriers to treatment. Four individuals had desensitization plans. The monitoring team received progress notes, but not the desensitization plans.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	In order to assess compliance with this provision, the monitoring team reviewed records, documents, and facility-reported data. Interviews were conducted with the members of the clinic staff, medical staff, medical director, and medical compliance nurse. The monitoring team also attended several meetings in which the dentist was an active participant. The monitoring team also observed treatment provided to individuals in the dental clinic. <u>Staffing</u> The dental clinic staff was comprised of a dental director, staff dentist, two registered dental hygienists, two dental assistants, and an administrative assistant. The dental director increased his clinical hours to approximately 20 hours a week. These hours were devoted to completion of comprehensive annual assessments. <u>Provision of Services</u> MSSLC operated a fulltime dental clinic five days a week. Basic dental services were provided, including prophylactic treatments, restorative procedures, such as resins and amalgams, and x-rays. The total number of clinic visits and key category visits are summarized below.	Noncompliance

#	Provision	Assessment of Status	Compliance

Clinic Appointments 2012						
	March	April	May	June	July	August
Preventive	200	211	186	188	124	187
Restorative	51	46	33	48	48	47
Emergency	7	14	11	4	16	11
Extractions	5	4	6	3	0	7
Total Appointments	339	343	302	309	236	310

The overall number of clinic appointments remained unchanged from the last review. The number of visits was based on campus clinic data only. The majority of the off campus appointments were for extractions. The dental director reported that he was engaged in more clinical work (50%) and spent approximately 20 hours a week completing annual assessments. The staff dentist had no administrative duties and all of his time was devoted to clinical services and documentation of the services provided. He pointed out that getting individuals back into clinic was difficult due to the work load and that it often took a fairly long time to complete the work that needed to be done for some individuals.

The monitoring team observed, through record reviews, that completion of simple restorative work could take several months. Individual #169 was seen on 4/30/12 and was noted to have two dental caries that required restoration. There was documentation that one tooth was restored on 8/20/12. The status of the second tooth was not clear. Individual #455 was seen on 6/25/12 for an annual assessment and two dental caries were identified. The individual returned on 8/29/12 for prophylactic treatment. Another appointment in early August 2012 was missed. The records reviewed did not include any documentation of the planned restorations.

<u>Emergency Care</u>
Emergency care was available during normal business hours. After business hours, the on-call physician had access to the dental director by phone. Guidance could be provided on treatment and individuals referred to the local emergency department, if necessary. The monitoring team identified one individual who did not benefit from an evaluation due to the planned leave of the dental director and staff dentist. Emergency coverage was not provided as required. The individual was referred to the local emergency department. The dental director reported that a lack of a dentist was not a common event.

In order to evaluate the provision of emergency care, the IPNs from start of emergency to closure and a copy of the dental evaluation and treatment were requested. The facility submitted the dental treatment records for each individual who received emergency treatment.

#	Provision	Assessment of Status	Compliance
		For the most part, the individuals were seen quickly in the MSSLC clinic, received treatment, and completed x-rays when appropriate. Referrals were made to Scott and White when necessary. Analgesia and antibiotics were prescribed as indicated. The 20 records reviewed included some findings that are worthy of noting because, in some cases, they illustrated issues that are discussed throughout this report: • Individual #215 was seen in clinic on 7/20/12. The dentist noted that the individual had lots of plaque and staff needed to assist with toothbrushing. • Individual #508 experienced tooth pain on 6/6/12. An emergency appointment was scheduled for that day. The individual did not show up for the appointment. The clinic was informed that the appointment was missed due to transportation problems. • Individual #287 was seen in the clinic on 5/25/12 for a post-op exam. The dental clinic notes indicated that extractions were completed at Scott and White earlier that day however, the dental clinic was not aware that this appointment was scheduled. • Individual #65 was seen in March 2012, May 2012, and July 2012 for emergency evaluations. In each instance, the individual had a history of "blows" to the face. • Individual #379 was seen on 5/1/12 because of a toothache. The individual had complained of pain in the past but refused treatment and restoration. The tooth was considered non-restorable at the time of the visit. <u>Oral Surgery</u> The monitoring team requested a list of individuals who received any dental treatment or assessment off campus. The facility submitted a list of 12 individuals. Many individuals were referred to Scott and White for extraction of third molars, but several had decayed teeth that were not molars. A number of individuals expressed a preference to have dental work done at Scott and White. This may be due to the fact that MSSLC does not utilize oral medications to achieve minimal sedation for dental procedures. Individuals who had oral surgery are discussed throughout this report. <u>Oral Hygiene</u> The facility tracked data related to oral hygiene for all individuals. Those data are summarized below.	

Oral Hygiene Ratings 2011 - 2012			
Quarter	Poor %	Fair %	Good %
1st	7	60	33
2nd	4	57	39
3rd	4	47	49
4th	4	41	55

#	Provision	Assessment of Status	Compliance
		The data reported indicated that oral hygiene ratings improved. Throughout various record and document reviews, there was evidence that many individuals were not receiving adequate home care or had less than satisfactory hygiene. The oral surgeon commented that one individual needed to have the remainder of his teeth removed due to poor oral hygiene and a poor prognosis. Another individual was denied further orthodontic treatment until oral hygiene improved. The IPN for Individual #369 included a note by the MSSLC dentist on 9/13/12 stating that DCPs did not brush her teeth and did not know if anyone else brushed her teeth. The note concluded with "It appeared that no one brushed her teeth." The data submitted included the oral hygiene ratings for five percent of the individuals who were edentulous. When the dental director was questioned as to whether that could spuriously improve the data of good oral hygiene, he answered no. The reason for the response was that most individuals who were edentulous at the facility had fair, and not good, oral hygiene. Again, this was indicative of a lack of good home care. There were no corrective action plans related to oral hygiene because the facility's data did not appear to warrant any particular action. Additional supports related to hygiene were provided at MSSLC. Four individuals received suction toothbrushing. Moreover, the PNMP was utilized to ensure positioning was adequate. Documentation of the PNMP review was not always found in the progress notes. <u>Staff Training</u> 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 dental clinic submitted a training roster for the direct care professionals. A total of 901 staff completed the training. This provision remains in noncompliance. The facility must ensure that services are being delivered in a timely manner and that a process is in place to provide the required emergency coverage. Moreover, the facility must further evaluate the status of the oral hygiene program and the care that is delivered in the home areas.	

<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 facility maintained a dental services policy. Changes were made in the provision of services that should have been included in the policy. The dental director reported during the last two compliance visits that the facially now required comprehensive examinations every six months. The dental services policy should be revised to reflect that change.

Annual/Comprehensive Assessments
In order to determine compliance with this requirement, a list of all annual/comprehensive 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. The available data were used to calculate compliance rates that are summarized below.

<table>
<tr><td colspan="7">Comprehensive Assessments 2012</td></tr>
<tr><td></td><td>March</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td></tr>
<tr><td>No. Exams</td><td>56</td><td>38</td><td>59</td><td>57</td><td>69</td><td>63</td></tr>
<tr><td>Compliant Exams</td><td>51</td><td>37</td><td>59</td><td>57</td><td>67</td><td>61</td></tr>
<tr><td>% Compliance</td><td>91</td><td>97</td><td>100</td><td>100</td><td>97</td><td>97</td></tr>
</table>

The overall compliance score was 97%. The comprehensive dental records for six individuals were reviewed. The following is a summary of information found in the most recent comprehensive dental assessment:
• 5 of 6 (83 %) assessments included an entry on cooperation, behavioral issues, and the need for sedation/restraint use
• 6 of 6 (100%) assessments had entries for oral hygiene, teeth and restorations, and periodontal conditions
• 6 of 6 (100%) assessments included documentation of oral cancer screenings
• 5 of 6 (83%) assessments included oral hygiene recommendations
• 6 of 6 (100) assessments documented the risk rating
• 4 of 6 (67%) assessments documented x-rays or the need for x-rays

The facility utilized the Dental Record Comprehensive Examination form to document annual assessments. The same information was also entered into the IPN as a dental progress note. The form was difficult to read and the two dentists utilized it differently. The yes and no responses were sometimes underlined and, in some instances, only one response was present. For some of the forms reviewed, the response could not be determined and some forms were signed by the dentist but not completed. Dental summaries were included in two of the records reviewed.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		As part of the facility's requirement to provide assessments and evaluate the quality of those assessments, the state dental service coordinator will need to develop tools to assess the quality of dental assessments. This should fold into the facility's dental peer review process. Management of assessments is discussed further in section H1. <u>Initial Exams</u> The facility submitted data for five individuals admitted since the last onsite review. All of the individuals completed initial dental evaluations within 30 days. <u>Dental Records</u> Dental records consisted of initial/annual exams, annual dental summary, dental progress treatment records, and documentation in the integrated progress notes. Providers documented in the integrated progress notes. An entry was also made in the dental treatment record. IPN entries were written in SOAP format and were generally dated, timed, and signed. During the March 2012 compliance review, the monitoring team surfaced concerns related to dental documentation. Similar issues were noted throughout this review and are presented in the various subsections of this report. The following case demonstrated problems related to the quality of documentation: • Individual #61 was referred to the emergency department on 7/26/12 for evaluation of jaw swelling. Computerized axial tomography was completed and the individual was prescribed doxycycline and discharged back to MSSLC. There was no discussion between the dentist and the PCP prior to transfer because there was no dentist on call. The individual was seen in dental clinic on 7/30/12. The dental progress notes simply stated the exam was due to swelling of the lower left jaw. An x-ray was completed and was negative. The plan was to see the individual back in one week. The next note, dated 8/6/12, stated that the individual was in for a post-op exam and everything appeared normal. • The MSSLC dental notes did not reflect at any point that the individual was seen in the emergency department, had a CT scan completed or was taking doxycycline. This was clinically relevant history that should have been a part of the dental assessment.	

#	Provision	Assessment of Status	Compliance
		Failed Appointments The facility reported data on refusals, failed/no show, and missed appointments. The numbers as identified and reported by MSSLC are summarized in the table below:	

	March	April	May	June	July	August
Refused	31	30	28	23	12	23
Missed	45	38	37	43	36	35
Failed	76 (22%)	68 (20%)	65 (21%)	66 (21%)	48 (20%)	58 (19%)
Total	339	343	302	309	236	310

The dental director generated a list of failed appointments at the end of each day. This was discussed at each of the unit meetings the following morning and documented in the minutes. The clinic's list of failed appointment included an explanation for each failure. Appointments were missed due to a number of reasons, such as medical appointments, illness, home visits, and community outings. There were many appointments that failed due to a lack of staff, transportation issues, records not being available, and appointments about which staff were unaware. The clinic implemented a protocol to address staff shortages. The dental clinic staff instructed residential staff to call their training supervisor and shift supervisor when staff shortages prevented individuals from attending clinic. This information was summarized in an email that was sent to the unit directors, home staff, and the facility director. This was a relatively new practice at MSSLC, so its effectiveness will need to be determined.

Dental Restraints

MSSLC did not utilize any sedation or anesthesia on campus. The number of individuals receiving general anesthesia at Scott and White is summarized below.

Sedation 2012						
	March	April	May	June	July	August
General Anesthesia	0	0	2	2	0	2

These data did not capture individuals who received IV anesthesia. The facility continued to report that pretreatment sedation was not used at MSSLC. There was an apparent failure to understand that it was necessary to identify those individuals who received such treatments off campus due to the potential effects and interactions with routine medications. Record reviews indicated that IV anesthesia and conscious sedation were used at Scott and White. Individual #379 was seen in the oral surgery clinic on 7/2/12 and was scheduled to have a single decayed tooth removed using IV anesthesia. Data related to appointments remained problematic. For example, Individual #287 had multiple extractions at Scott and White on 5/25/12, but notes and consultations were not provided in the document request. The medical department had a tracking log, but it

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		only included data for the past one to two months. As previously discussed, MSSLC did not utilize any pretreatment sedation, but there was no obvious rationale for that decision. It was clear that many individuals needed services at Scott and White, and some were for single extractions for individuals who requested some form of sedation. Scheduling these procedures took several weeks to months. While the monitoring team is not encouraging the use of sedation, there are likely some individuals who might benefit from the safe administration of oral medications to achieve anxiolysis/minimal sedation in the dental clinic. The monitoring team recommends that the state dental services coordinator conduct an assessment of MSSLC in regards to this matter. Strategies to Overcome Barriers to Dental Treatment The clinic failure rate for the reporting period was 20%. The dental director distributed data related to missed appointments and oral hygiene status at the end of each day. This information was discussed in the unit meetings. The dental director reported that he followed up on the discussions by reading the unit meeting minutes. The facility implemented a desensitization committee. The committee met monthly to discuss every individual who refused dental treatment or exhibited difficult behaviors in clinic. The monitoring team attended this meeting and observed that the committee referred the problem to the team along with recommendations that could include team consultation with the psychologist regarding desensitization. Most individuals were referred for development of plans, such as SAPs. The monitoring team reviewed several of the ISPAs provided, most of which occurred prior to the development of the desensitization committee. Desensitization plans were also developed. There were four plans implemented at the time of the review. The monitoring team, as always, requested copies of all desensitization plans and documentation of monitoring and progress. The plans were not submitted. A single progress note was provided for each of the four individuals. Individuals who refused treatment once they arrived to the clinic were not counted as refusals although it appeared that they were also discussed in the desensitization committee meeting. The current data classification scheme does not provide the best reflection of failed appointments at MSSLC. The fact that individuals who refused treatment upon arrival to clinic are classified as other and not as refusals actually minimizes the refusal rate at MSSLC. This provision remains in noncompliance.	

Recommendations:

1. The dental director should evaluate the provision of services at MSSLC to determine if individuals are receiving treatment such as restorations in a timely manner. Corrective actions should be implemented as warranted (L1).

2. The dental director must ensure that emergency coverage is provided in accordance with facility policy. Since the staff dentist does not take call, arrangements will need to be made in the absence of the dental director (L1).

3. The facility must ensure that community resources are utilized as needed to provide advanced services to individuals supported by the facility. Data related to the provision of those services must be accurately documented (Q1).

4. The facility must ensure that those with poor oral hygiene have adequate plans in place to assist in improvement of oral health. Individuals who demonstrate deterioration in hygiene status should also have development of a plan (Q1).

5. The facility should develop a policy for suction toothbrushing (Q1)

6. Given the multiple reports of poor hygiene encountered in record reviews and the dental director's comments on the oral hygiene of edentulous individuals, the facility must examine the current oral hygiene program and the care that is being provided in the homes (Q1).

7. Policies and procedures should be updated to reflect current practices (Q2).

8. The state dental services coordinator should develop tools to determine the quality of the dental assessments completed at the facility (Q2).

9. MSSLC must report data on the use of sedation and general anesthesia for on-campus and community appointments (Q2).

10. The facility should review the accuracy of the dental data ensuring that all refused appointments are being adequately captured (Q2).

11. The Desensitization Committee should continue its review of individuals who refuse treatment being mindful of the need to have adequate follow-up when individuals are referred to the IDT (Q2).

12. The facility must address the problem of missed appointments due to staffing, transportation, unknown appointments, etc. (Q2)

13. The state services dental coordinator should review the practice at MSSLC of prohibiting the use of oral pretreatment sedation for dental clinic (Q2).

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Admissions list o Budgeted, Filled, and Unfilled Positions list, Section I 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 Communication Master Plan o Speech Pathology Assessment template**s** o Augmentative Communication Spreadsheet o Individuals with Behavioral Issues and Coexisting Language Deficits o Individuals with PBSPs and Replacement Behaviors Related to Communication o List of individuals with PBSPs o List of individuals with AAC o List of common area AAC devices o List of individuals receiving direct speech services o Behavior Therapy Committee meeting minutes o OT/PT/SLP Assessment template o NEO curriculum materials related to PNM, tests and checklists o Consultation Spreadsheet o Assessment Tracking Log o Communication Assessments, ISPs, and ISPAs for the following: • Individual #254, Individual #67, Individual #70, Individual #505, Individual #372, and Individual #391. o Communication Assessments, ISPs, ISPAs, SPOs, and communication and AAC-related documentation for the following: • Individual #503, Individual #16, Individual #328, Individual #427, Individual #40, Individual #321, Individual #873, Individual #390, Individual #455, and Individual #185 o Communication Assessments for individuals recently admitted to MSSLC: • Individual #700, Individual #873, Individual #838, Individual #754, and Individual #927 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy

	tab, and Nutrition tab, for the following: • Individual #432, Individual #533, Individual #281, Individual #140, Individual #120, Individual #369, Individual #178, Individual #197, Individual #435, Individual #341, Individual #436, Individual #72, Individual #38, Individual #226, Individual #188, Individual #427, and Individual #291, Individual #477, Individual #151, Individual #391, Individual #257, and Individual #1. o PNMP section in Individual Notebooks for the following: • Individual #432, Individual #533, Individual #281, Individual #140, Individual #120, Individual #369, Individual #178, Individual #197, Individual #435, Individual #341, Individual #436, Individual #72, Individual #38, Individual #226, Individual #188, Individual #427, and Individual #291, Individual #477, Individual #151, Individual #391, Individual #257, and Individual #1. o Dining Plans for last 12 months and PNMPs for last 12 months for the following: • Individual #432, Individual #533, Individual #281, Individual #140, Individual #120, Individual #369, Individual #178, Individual #197, Individual #435, Individual #341, Individual #436, Individual #72, Individual #38, Individual #226, Individual #188, Individual #427, and Individual #291, Individual #477, Individual #151, Individual #391, Individual #257, and Individual #1. <u>Interviews and Meetings Held</u>: • Brandie Howell, OTR Habilitation Therapies Director • Karen Davila, MS, CCC-SLP • Various supervisors and direct support staff • PNMT meeting <u>Observations Conducted</u>: • Living areas • Dining rooms Day Programs and work areas
	Facility Self-Assessment: In the self-assessment, Brandie Howell, OTR, the Habilitation Therapies Director, attempted to outline her specific assessment activities. In many cases, however, these would not lead the facility to achieve substantial compliance with this provision. For example, she reviewed the number of assessments completed in a four month period (April 2012 to July 2012), however, there were no measurable outcomes established. Her finding was that 41 assessments, 21 updates, and seven consults were completed as required. She concluded that because there were no outstanding assessments, she was at 100% compliance. In her presentation at the monthly PET meeting, she presented additional information that did not have any meaning or context and, as such, was not useful in any way. For example, she reported that two staff attended ISPs, though it was not known how many ISPs had been held. She reported that 11 individuals were identified as needing speech services, yet 104 were enrolled in these services. She

	reported that there was one SAP and 103 activity plans. This would lead one to believe that there were extensive supports provided to a large number of individuals when, in fact, activity plans were for the therapists to conduct quarterly monitoring of communication dictionaries only. These were staff aids rather than individualized communication supports for the individual. The Presentation Book provided a plethora of documents that did not relate to the action plan or self-assessment activities. There was no effective analysis of the findings, accomplishments, and work products. While the existing audit tool was referenced, it was not heavily relied on for self-assessment, but this was a positive step. While some elements may be valuable in assessing compliance with this provision, others were not and, as recommended during previous reviews, this tool should be revised to better reflect what is meaningful. All of the elements were reported as 100% and, as such, did not drill down to what was needed to assess areas that needed improvement. The activities for self-assessment listed for each provision were numerous and will not be listed here. The findings were presented in narrative form and it may be useful to supplement that with data in a graph or table format to illustrate change and improvements over time. An action plan to address identified issues should illustrate how Ms. Howell would intend to proceed toward compliance. The facility self-rated itself as noncompliant with all four items of R (R1 through R4). While actions taken showed some steps in the direction of substantial compliance, the monitoring team concurred.
	Summary of Monitor's Assessment: Staffing levels were decreased at the time of this review. Though assessments had been completed for each individual, the quality of those was poor. As always, the SLPs were responsible for communication supports and mealtime supports for all of the individuals, and responsibility for the PNMT was also assigned to one SLP, though no one currently filled that role at the time of this review. The current ratio for caseloads continued to be high. There was an urgent need to fill the vacant positions and/or securing contract therapists. Consideration of those with extensive experience with AAC and adults with developmental disabilities is critical. NEO training was very limited related to communication and increasing the time allotted to this should be considered. Training should focus on teaching staff to be effective communication partners as well as to implement AAC. Staff tend to see these systems as an exercise or a single activity rather than as a way to interact with others. This cannot only be taught or trained in an inservice class, but rather modeled and coached in the moment. Integration of communication strategies and AAC systems should not be the sole responsibility of direct support and day program staff. Engagement in more functional skill acquisition activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be an ongoing 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

	these programs for individuals and groups. This requires significant time from the professional staff. The completion of assessment is but a step in the continuum of the provision of communication services. The therapists are encouraged to step up their efforts to immerse themselves into the routines of the individuals they support to capitalize on the teachable moments with staff so that they may learn to capture teachable moments with individuals.

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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.	<u>Staffing</u> At the time of this review, there were two full-time SLPs, Karen Davila, MS, CCC-SLP, and David Ehrenfeld, MA, CCC-SLP. Ms. Davila began working at MSSLC in July 2012. Per the list submitted to the monitoring team, there were five budgeted positions. Two contract SLPs were listed, but at the time of this review neither was working at MSSLC. This list indicated that there were two positions filled and three unfilled positions. The documented ratio was 4:354 or approximately 1:88. Given the current staffing the actual ratio was 1:186. Each clinician provided both communication and dysphagia supports and services. This ratio was grossly inadequate to provide appropriate supports and services in these two key areas. The identified caseloads were as follows: • Davila: Shamrock, Longhorn, and 68/57 • Ehrenfeld: Barnett, Whiterock, 60/77, Martin 1-8, and 93 <u>Qualifications</u> • 2 of 2 SLPs (100%) were licensed to practice in the state of Texas. Evidence that the facility consistently verified both state licensure and ASHA certification for each clinician will be requested prior to the next compliance review. <u>Continuing Education:</u> A list was submitted as evidence of participation in communication-related continuing education in the last 12 months. • 1 of the 2 (50%) current SLPs participated in continuing education related to communication including the following: o Memory by Institute of Brain Potential The number of contact hours or CEUs was not listed. The monitoring team strongly urges that each of the clinicians be supported to participate in further communication-related continuing education courses over the next year. This is critical to ensure improved clinical assessment and program development for AAC and language for individuals with developmental disabilities.	Noncompliance

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		Facility Policy No local policy existed for the provision of communication services at MSSLC, however, the facility later reported that one did exist. Even so, the following components should be considered in the development of such a policy: • Outlined assessment schedule • Timelines for completion of new admission assessments (within 30 days of admission or readmission) • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.) • Frequency of assessments/updates • Timelines for completion of comprehensive assessments (within 30 days of identification via screening, if conducted) • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT) • A process for effectiveness monitoring by the SLP • Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment • Methods of tracking progress and documentation standards related to intervention plans • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution This provision item was not in substantial compliance due to the diminished staff ratios at the time of this review and limited continuing education attended by speech clinicians. The facility did not provide an adequate number of speech language pathologists or speech assistants with specialized training or experience as further evidenced by noncompliance with R2 through R4 below.	
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	Assessment Plan The Master Plan, dated 9/4/12, indicated that all individuals identified as Priority 1, 2, and 3 had been provided a comprehensive communication assessment, though the dates of these were not listed in the plan. None of the existing communication assessments had been audited to determine if they met the current state-established format and content guidelines and if they had been completed in a timely manner prior to the ISP. The tracking log submitted listed 106 assessments as completed in the last six months since the last review. Nine of these (8%) were not completed on or before the due date listed. These assessments included comprehensive assessments, baseline assessments for individuals newly admitted to	Noncompliance

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	interventions.	MSSLC, updates, and Community Placement (CLDP) assessments. Based on review of the documents submitted: • 18 of 24 individuals (75%) admitted during the last six months received a communication screening or assessment. As admission dates were not listed, it was not possible to determine if these were completed within 30 days of admission. Each was listed as completed on or before the due date identified in the tracking log submitted. Six other individuals listed as newly admitted to MSSLC were not included in the tracking log (Individual #653, Individual #888, Individual #851, Individual #997, Individual #671, and Individual #652). • Rather than a screening, comprehensive assessments and updates were completed. • 97 of 106 individuals (92%) had communication assessments completed on or before the due date listed in the tracking log. Specific ISP dates were not listed so it could not be determined if they were completed within 10 days of the annual ISP. For the month of August 2012, there were 14 communication assessments listed as due per a list included in the Presentation Book. Only 57% of those were submitted 14 days before the ISP per this document. It was not known to the monitoring team what the MSSLC established timeframe was for clinicians to submit assessments prior to the ISP, though state guidelines required 10 working days. <u>Communication Assessments</u> Communication assessments were requested and submitted as follows: • Individuals in the sample selected by the monitoring team (23 of 23 were submitted) • Five of the most current assessments by each speech clinician (six were submitted for two SLPs currently employed) • Individuals newly admitted to MSSLC (five were submitted) • Individuals who participated in direct communication intervention, had SAPs, were provided AAC, had PBSPs, and/or presented with severe language deficits (assessments for 11 individuals were requested and nine were submitted). In a number of cases, a comprehensive or baseline assessment had been previously completed and some annual updates were also provided. Examples included Individual #72, Individual #391, Individual #435, Individual #1, and Individual #281. The most current assessments for some individuals were completed more than 12 months ago, though annual assessments/updates would be expected for each based on supports and services or assessment recommendations (Individual #291, Individual	

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		#257, Individual #151, Individual #40, Individual #175, Individual #455, and Individual #140). The assessment for Individual #328 was not current within the last 12 months. The most current assessments for Individual #427 (1/18/12), Individual #391 (5/3/12), and Individual #873 (8/22/12) were duplicated in multiple requests. All totaled, there were current assessments for 33 individuals available for review. Eighteen of these were updates to a previously completed comprehensive assessment. These were intended to addend a previously completed comprehensive assessment and, as such, contained abbreviated content to update the individual's current year status. The original comprehensive or baseline assessments, as well as all additional subsequent annual updates, were included in the individual records for four individuals: Individual #72, Individual #1, Individual #391, and Individual #435. Annual updates were missing for Individual #436 (2011), Individual #38 (2010 and 2011), and Individual #281 (2010). A fourth update was completed for Individual #38 on 8/23/12 rather than another comprehensive or baseline assessment. There were 10 comprehensive assessments, four baseline assessments, and one baseline comprehensive assessment. A template for the speech pathology assessments was submitted as adopted at MSSLC in September 2011. No content guidelines were submitted and the same format was used for all three assessments. The Augmentative and Alternative Communication Profile by Tracy M. Kovach, Ph.D. (LinguaSystems, 2009) was also submitted as an assessment tool for AAC. None of the assessments submitted were fully consistent with the template submitted. Only two assessments included any factors or considerations for community placement (Individual #873 and Individual #185). A number of the others also omitted other key headings, including AAC and expressive language (Individual #587, Individual #427, Individual #120, Individual #533, and Individual #432). In many cases, though a heading was included, the content was limited and not thorough or comprehensive. There was no heading or content related to personal likes, dislikes, or preferences and this was not reported by the clinicians in the assessments reviewed 0 of 33 individuals had comprehensive assessments that contained <u>all</u> of the 23 elements outlined below. These were the minimum basic elements necessary for an adequate comprehensive communication assessment as identified by the monitoring team. Many of these elements were missing or they were inadequately addressed. The current state assessment format and content guidelines generally required that these elements be contained within the assessments. There were no content guidelines used by the clinicians to ensure that the required content was addressed in each assessment. The elements most consistently included were: • Dated as completed 10 days prior to the annual ISP • Description of verbal and nonverbal skills with examples of how these skills	

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		were used functionally throughout the day. • Description of receptive communication skills with examples of how these skills were utilized in a functional manner throughout the day. • Comparative analysis of current communication function with previous assessments • Identify need for direct or indirect speech language services • Reassessment scheduled • Manner in which strategies, interventions, and programs should be utilized throughout the day The percentage of assessments that included each individual element are listed below: • Dated as completed 10 days prior to the annual ISP (88%). • Diagnoses and relevance of impact on communication (0%). Most assessments merely listed the diagnoses. • Individual preferences, strengths, interests, likes, and dislikes (0%). • Medical history and relevance to communication (0%). This section merely listed diagnoses. Relevance to communication was not discussed. • Medications and side effects relevant to communication (3%). Most of the assessments listed the medications and some identified general side effects. None identified issues that would specifically impact communication abilities. • Documentation of how the individuals' communication abilities related to their health risk levels (0%). • Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day (55%). It was noted that even in some assessments that this was addressed, the content was very limited. • Description of receptive communication skills with examples of how these skills were utilized in a functional manner throughout the day (61%). • Evidence of observations by SLPs in the individual's natural environments (day program, home, work) (12%). • Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal (0%). The clinicians did not provide examples of information included in the dictionaries, did not discuss if these were still accurate and effective, and did not discuss specific changes needed. Some of the statements were merely rote descriptions of how a communication dictionary could assist staff. • Discussion of the expansion of the individual's current abilities (21%) • Discussion of the individual's potential to develop new communication skills (9%).	

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		• Effectiveness of current supports, including monitoring findings (0%). This was not consistently present in the assessments reviewed and none presented findings from monitoring conducted throughout the last year. • Addressed the individual's AAC needs including clear clinical justification and rationale as to whether the individual would benefit from AAC (27%). Content varied greatly. In most cases, the clinician stated that AAC was not appropriate for the individual with insufficient rationale. See examples below. • Comparative analysis of health and functional status from the previous year (0%). • Comparative analysis of current communication function with previous assessments (45%). • Identify need for direct or indirect speech language services (79%). • Reassessment schedule (91%). • Monitoring schedule (0%). • Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits (12%). • Factors for community placement (3%). • Recommendations for services and supports in the community (0%). • Manner in which strategies, interventions, and programs should be utilized throughout the day (82%). In the cases that specific communication strategies were listed in the assessment, they were generally functional and could be applied throughout the day. Many did not address methods to address this via skill acquisition or availability during meaningful activities. Additional findings: • 16 of 33 (48%) assessments contained five or fewer of the elements outlined above. • 17 of 33 (52%) assessments contained six to 10 of the elements outlined above. • 0 of 33 (0%) assessments contained 11 to 15 of the elements outlined above. • 0 of 33 (0%) assessments contained more than 15 of the 23 elements above. • None of the assessments submitted were completed per the assessment format submitted as current. Augmentative/Alternative Communication and Assistive Technology: Content in this section was very poor and incomplete. No one appeared to have been provided a comprehensive assessment for AAC use. Being verbal and using speech would not automatically be a reason to not provide AAC, but this appeared to be a standard practice. The therapists appeared to believe that using the hands was the only viable access method. In many cases, AAC was ruled out for a number of individuals with	

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		inadequate or inappropriate rationale. Some examples included the following: • Individual #120 (3/1/12): She was described with a severe speech handicap in which meaningful speech was absent or limited to a few simple words. AAC was deemed unnecessary because she used speech as her primary mode of communication. AAC assessment was not conducted. • Individual #188 (4/19/12): The only attempt to assess AAC was using a voice output device during an assessment session. Since she required hand over hand assistance and resisted this, AAC was not recommended. No other methods were attempted. • Individual #281 (6/19/12): AAC was ruled out because he was an effective nonverbal communicator and displayed no interest in switch activated devices. No other types of AAC were explored. • Individual #1 (8/14/12): AAC was deemed inappropriate though he was described as essentially nonverbal. He was reported to give staff objects to make requests (hands cup to staff when he was thirsty) or taking staff to the stereo to listen to music. It was reported that he did not have the capacity or desire to participate in an assessment for AAC. Assessment, however, can be conducted over a long period of time and should be related to meaningful activities. AAC could have been used as a replacement for, or expansion of, his current communication style. His capacity for assessment should not factor into his readiness or potential for AAC use. The clinician's role is to find an alternate method to gather information. • Individual #427 (1/12/12): Though it was reported that he had two voice output devices, there was no evidence that the clinician observed him using these, but rather reported what had been documented in previous assessments. No AAC assessment was conducted. • Individual #390 (11/1/11): A real object communication system was recommended, but there was no rationale for the selection of this. It was noted that this had never been implemented for him. • Individual #197 (6/6/12): AAC was not applicable because he was reported to lack the skill of representation. This is absolutely not a prerequisite to effective AAC use. Clinical Impressions: The analysis sections of these reports continued to be weak and provide insufficient rationale for the recommendations. The assessments did not identify important life activities or inventory ways for greater meaningful participation in them. The assessments did not identify preferences, likes, or dislikes. These were important	

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		for establishing contexts for communication opportunities, but the clinicians did not establish a link between these and functional participation in the daily routine. Observations in natural environments would also provide clues as to preferences as well as individual potentials for enhancing or expanding existing communication skills. There were 56 individuals listed with severe language deficits (15% of the current census). Thirty-eight (68%) of these individuals were listed as nonverbal, of whom 23 were identified as Priority 1. Each was identified with a completed communication assessment though the Master Plan did not list when these had been completed. Another 15 were identified as Priority 2 or 3, and each was listed with a completed assessment. <u>SLP and Psychology Collaboration</u> There were 253 individuals identified with PBSPs and replacement behaviors related to communication. There were 346 individuals listed in the Master Plan. It was not possible to determine if each of the individuals with communication-related replacement behaviors in the PBSP had received a current comprehensive communication assessment. Five of these individuals were included in the sample selected by the monitoring team and were reviewed to determine if the communication strategies identified were integrated into their plans (Individual #120, Individual #427, Individual #257, Individual #281, and Individual #436). There was no collaboration of speech and psychology or integration in the PBSPs or ISPs as evidenced in the following examples: • Individual #281: The most current communication assessment was a comprehensive assessment dated 6/19/12. He was identified as nonverbal and Priority 1 for communication supports. The communication assessment documented that he had a PBSP targeting aggression (yelling and spitting). Staff reported that this occurred when he was asked to participate in activities or carry out routine daily tasks. The evaluator stated that AAC was not appropriate because he effectively communicated nonverbally and was not interested in switch activated devices. It was of concern that the clinician appeared to believe that switch activated devices were the only form of AAC and that Individual #281 communicated effectively given that he required a behavior plan for aggression. There was no evidence that the clinician had attempted to collaborate with psychology to address his needs. His ISP outlined that a communication dictionary be monitored quarterly by the SLP. There was no SLP at the ISP meeting on 8/17/12. • Individual #120: Her most current communication assessment was a comprehensive assessment dated 3/1/12. Her PBSP was dated 3/28/12 and targeted aggression toward others and screaming. The replacement behavior was raising or waving her hand or any other method to indicate that she was upset. The PBSP indicated that her screaming was to communicate a desire to escape because the environment was too noisy or others were too close. The	

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		communication assessment indicated that the screaming behavior was to indicate she wanted to go outside or otherwise get attention. A previous assessment suggested that speech and psychology collaborate to develop a plan to assist her to communicate appropriately. There was no evidence that this had occurred and there were no recommendations in the current assessment to do so. It was reported that AAC was not indicated because she used speech as her primary mode of communication and communicated her needs independently. It was stated that staff should prevent behavioral episodes through interactive communication though no strategies to do so were offered. The ISP dated 3/28/12 referenced information from a previous communication assessment dated 2/7/11, rather than the more current one. The actual availability of the most current assessment to the team was questionable because it was stamped 4/2/12, after the ISP meeting was held. • Individual #436: His most current assessment was an update on 3/20/12 and his PBSP was dated 3/26/12 targeting aggression toward others, ingesting inedible objects, and refusal to follow instructions or programming. None of the concerns described in his PBSP were discussed in the communication assessment and there was no evidence of collaboration between these team members. His speech was characterized by a moderate articulation deficit and decreased intelligibility. The assessment stated that he had made progress and it also stated that he had a decline in progress. A program plan was indicated for daily use in the home, at any rate. A Speech Pathology program plan to address speech intelligibility to maintain and improve speech ability was listed as a recommendation. There was no evidence that this had been provided since the assessment. The IDT indicated that they believed that he would benefit from some type of electronic AAC device. There was no SLP present at his ISP on 4/17/12. The assessments referenced were completed in 2009, 2010, and 2011, rather than the most current assessment. • Individual #427: His most current assessment was an update on 1/12/12. His PBSP was dated 2/14/12 targeting SIB. The recommended replacement behavior was identified as appropriately seeking positive attention because this was the primary function of the maladaptive behavior. The PBSP also stated that some of his behavior may be the result of frustration from the inability to communicate a want, need, or discomfort. He was reported to be nonverbal, but was able to respond to some yes/no questions. His communication assessment indicated that he was to begin use of two single switch buttons in his home, but staff were not aware of these and suggested that they were used in his classroom. There was no AAC assessment in the current update and it was only stated that he would continue to benefit from the communication dictionary. There was no indication that the SLP had any plans to be involved in addressing his AAC use other than a service objective in the ISP. There were no training	

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		objectives involving AAC or switches in his ISP dated 2/14/12. • Individual #257: The most current communication assessment was 8/23/11. Her PBSP targeted rage reactions and was dated 7/10/12. Replacement behaviors included engagement in appropriate sensory stimulation and included some of the strategies from the previous communication assessment. As such, it was unfortunate that a more current assessment was not available or that there had not been collaboration between speech and psychology. An activity plan with quarterly monitoring by speech was recommended for a switch to activate a radio. There was no evidence of this in her individual record. Behavior Management Committee meeting minutes for the last six months were requested, though only minutes from 4/2/12 to 6/25/12 were submitted. A SLP attended 13 of 14 meetings. This is a key opportunity for discussions regarding effective communication strategies and for collaboration between the SLPs and psychologists in the review of PBSPs. There was, however, potential for additional collaboration. The current communication assessment format included a section titled Behavioral Considerations, which indicated if the individual had a PBSP and the types of behaviors noted during the assessment. While each of these were steps toward compliance in this area, the quality of content of this section varied greatly across assessments, did not describe any collaboration between these disciplines, and was not used in the analysis of assessment findings section for the design of communication supports and services, or for making recommendations. <u>Assessment Audits</u> There was no documented evidence of a formal or informal system of communication assessment audits. Reviews conducted pertained only to the completion of annual assessments and the number of individuals identified as needing AAC. There was a clear need for a formalized process to establish clinician competency and ensure ongoing compliance with the assessment format and content guidelines in a constructive learning context. This provision of section R2 of the Settlement Agreement was not in substantial compliance due to the documented weaknesses in the existing assessments and the absence of a system of assessment audits.	

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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> Based on review of the sample of ISPs, the following was noted: • At least 24 of the individuals for whom assessments were submitted had documented communication needs. ISPs were available for review for 21 of these. Each of the ISPs submitted and reviewed was current within the last 12 months. • In 10 of 21 current ISPs reviewed (48%) for individuals with communication needs, an SLP attended the annual meeting. • In 2 of 5 current ISPs (40%) reviewed for individuals with AAC, AAC was referenced (Individual #427 and Individual #321), though how these were used by the individual was not described. In two ISPs, there was no reference to AAC (Individual #40 and Individual #185). In the case of Individual #38, a Big Talk device was identified in his ISP, though he was listed with a Go Talk 4 Plus device. Training objectives for AAC use were not noted for any of these. Only communication dictionaries were provided to 13 individuals. • 18 of 21 ISPs reviewed (86%) included a description of how the individual communicated, but did not include how they used their AAC system (if he or she had one). Most of the descriptions, however, were minimal and did not provide a functional description of how the individual communicated or ways staff could effectively communicate with them. • 0 of 21 ISPs reviewed (0%) contained skill acquisition programs related to communication skills developed by the SLP. Five ISPs reviewed did not address communication objectives of any kind (Individual #391, Individual #435, Individual #197, Individual #281, and Individual #1). Twelve contained service objectives for monitoring, assistance, or for assessment by the SLP. Individual #390's ISP (11/16/11) contained a service objective for a real object communication system with trial and training. There was no evidence that this had occurred, however. Eight contained training objectives related to communication developed through the day program, but with no clear contribution or supports provided by the SLP. Many of these were not focused on meaningful, functional communication skills for the individual: o Individual #185: State the day and month of her birthday. o Individual #477: Continue to say hello and goodbye. o Individual #72: Touch radio to make a choice. Only five were reasonably functional. Some examples included: o Individual #427: Touch one of two musical instruments to make a choice. o Individual #70: Point to "help" in picture wallet to seek assistance. o Individual #341: Raise hand to get staff attention.	Noncompliance

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		AAC Systems It was reported that 109 individuals at MSSLC were provided a communication dictionary. Two individuals were provided a sign language dictionary. Of these, there were 15 individuals who were also provided one or more types of low/light tech AAC, including communication wallet (4), sign language book (1), picture magazine (1), Go Talk 9 Plus (1), Go Talk 4 Plus (2), visual activity schedule (1), Big Step by Step (4), Cheap Talk 8 on the Go (1), Big Talk Triple Play (1), Big Mack Switch (2), medical communication board (1), and access to a general use communication system (1). There were five individuals who were not provided a dictionary, but were provided with communication wallets (5) and one also had access to a general use picture board. There were two individuals who were provided environmental control devices. There were 142 individuals identified as Priority 1 and 2 who could potentially benefit from AAC. At least 60% of these individuals were nonverbal and others presented with limited verbal skills. It was of concern that AAC had been provided to only 21 individuals, 10 of whom had not even been included in these priority groups. This amounted to only 15% of those identified by the facility to be of highest priority for communication supports. Over 75% had been provided communication dictionaries, which, for the majority, was the only communication support provided. The monitoring team considered this to be an inventory of the communication system(s) used by the individual and serves as an interpretive guide for staff rather than a specific AAC system of communication for the individual. The self-assessment identified that the overall compliance score was 100% for assessment completion and the identification of communication needs. It was reported that 40 of 69 individuals required AAC, though there were actually only 21 individuals listed with individual AAC, other than a general use device or communication dictionary. Thus, this was not accurately reported in the self-assessment by the Habilitation Therapies Director. Since most of the supports provided to those with an identified need were limited to communication dictionaries only, this appeared to be a misrepresentation of the number of individuals who were actually provided AAC at MSSLC. A communication dictionary is an aid to staff for interpretation of existing communication efforts by an individual, rather than a system to be used by the individual to expand, improve, or enhance his or her own communication skills. It appeared that the communication dictionaries were frequently used in place of a personal AAC system. As described above, the assessment of AAC by the clinicians was extremely weak and many individuals were determined to be unable to use AAC. There appeared to be a consistent view that, if the individual did not spontaneously use the system, the individual would not benefit from AAC use. AAC was dismissed when an individual failed to activate a switch during an assessment rather than incorporated into meaningful	

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		activities. In some of those cases, there was no plan to provide SAPs or other supports to promote skill acquisition related to AAC. The clinicians are strongly encouraged to approach assessment and the provision of supports with the recognition that meaning and language is learned and device use may be a media for learning. Use may increase as meaning is attached through learning in a functional context. There were also other individuals with limited communication skills, ineffective skills, or challenging behaviors related to communication issues who would benefit from communication supports. AAC was provided to only six individuals who were considered to be Priority 1, two for individuals listed as Priority 2, and four for individuals identified as Priority 3. A number of others were not included in the Master Plan. Consistent implementation was another ongoing concern and, as such, meaningful and functional use by the individuals often did not occur and was not observed by the monitoring team. There was no evidence of communication plans for staff reference and implementation. <u>Direct/Indirect Communication Interventions:</u> Generally accepted professional standards of care for documentation by the SLP related to communication interventions include the following: • Current communication assessment identifying the need for intervention with rationale. • Measurable objectives related to functional individual outcomes included in the ISP. • Routine IPN or other SAP documentation contained information regarding whether the individual showed progress with the stated goal. • Routine IPN or other SAP documentation described the benefit of device and/or goal to the individual. • Routine IPN or other SAP documentation reported the consistency of implementation. • Routine IPN or other SAP documentation identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. • Termination of the intervention was well justified and clearly documented in a timely manner. Communication-related interventions were listed as provided for two individuals (Individual #140 and Individual #873). The focus for Individual #140 was a program for articulation, and treatment for following directions for Individual #873. Communication assessments were submitted for each individual as follows:	

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		• Individual #873: Baseline Assessment (8/22/12). • Individual #140: Update Evaluation (8/4/11). This assessment was reported to be an update to a baseline assessment on 6/22/10, though this was not submitted. This assessment was not considered to be current within the last 12 months as would be expected. As noted, only one individual with communication interventions had a current assessment, the other was expired at the time of this review. The facility intended to provide interim assessment updates for individuals who received communication supports, but this was not noted. Recommendations for these interventions were supposed to be included in the assessments and integrated into the ISPs for each individual along with functional measurable objectives. Communication-related intervention was not included in the ISP for Individual #140 and an ISP was not submitted for Individual #873. Only the documentation for Individual #140 generally met the basic minimum standards listed above (with the exception of a well-justified termination of the intervention). Therapy was discontinued because the individual was moving to a new home. The clinician documented that the goals would have been addressed further by extending the trial an additional two to four weeks, if he were not moving to a new home. Even so, while missing a couple of sessions be acceptable, it did not make sense to discontinue the therapy all together after only five sessions. As such, the provision of these interventions did not meet basic minimum standards for speech services. One other individual was provided a communication-related intervention, though he was not listed as such (Individual #455). His most current assessment was a baseline evaluation dated 1/6/11, significantly expired at the time of this review, though he had received therapy through 12/30/11 and an update (at a minimum) would be expected. Three measurable training objectives were identified with general instructions provided for staff implementation five times per week for 15 to 30 minutes. There were no instructions for documentation and the data collection form was not submitted. The notes by the SLP identified ongoing issues related to documentation by staff, yet there did not appear to be a clear mechanism or guidelines for them to do this. The manner in which goals were stated would make documentation difficult for staff without clear instructions, training, and oversight. The program was continued month to month without specific data, but rather only informal reports by staff. Indirect communication supports were provided for a number of individuals in the manner of monitoring of communication dictionaries and other AAC devices. This was accomplished through the establishment of activity plans (104 per the self-assessment).	

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		The activity plans were for documenting clinician activity for the purpose of quarterly review to ensure the dictionary was available, rather than activity or program plans in which the individual was actively engaged in skill acquisition and learning. The self-assessment for this provision reported that 149 individuals received AAC services and that 100% of individuals who needed devices had been provided them. As stated above, however, the assessment for AAC was weak and it was likely that many other individuals who would benefit from AAC had not been appropriately identified with such needs, beyond the provision of a communication dictionary. It appeared that the provision of the dictionary and the activity plan for monitoring these was the extent of services for many individuals. In addition, the number of individuals with AAC in the self-assessment was inconsistent with other documentation submitted to the monitoring team. <u>Competency-Based Training and Performance Check-offs</u> New employees participated in NEO classroom training prior to their assignment in the homes. The training curriculum and competency check-offs for communication were not submitted as requested (PNM-related NEO Curriculum in section O). Samples of a Communication Dictionary and a Communication Device Instructions document were submitted. It was not a competency check-off form. There was no content as to how to use dictionary or instruction sheets and no general content related to communication or how to be an effective communication partner. This was not adequate content for NEO training in this area. The schedule submitted outlined that 1.25 hours was allotted for Deaf Awareness training and 1.00 hour was allotted for Alternate Communication. This amount of time was sorely inadequate to teach the necessary skills, provide opportunities for active practice of the skills, and teach strategies for effective communication partners. Three to four hours is the minimal needed to ensure that staff can have the adequate time to absorb the information presented, practice the application of concepts learned, and demonstrate competency. There was no evidence that communication was taught as an aspect of the annual block refresher training. Much of the interaction of staff with individuals observed by the monitoring team was specific to a task, with little other interactions that were meaningful. Sometimes, there was a tremendous amount of staff talking to/at the individuals during activities, but without appearing to understand how to facilitate better interaction, engagement, and participation with the individuals. • Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology where appropriate) should continue to be a priority. This will only be possible when the clinicians are sufficiently available	

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		to routinely model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. The monitoring team observed a leisure recreation group that did not provide meaningful/functional activities. It would be a prime area for supports to be provided by speech clinicians to promote opportunities for communication-based activities. • SLPs should participate in co-designing written programs and providing formal training. Implementation should be collaborative with demonstration in real time activities. Many of the communication strategies outlined in assessments or the ability to incorporate assistive technology will not be naturally intuitive for direct support professionals. • Group and individual activities should be routinely co-directed by speech clinicians and DSPs in the homes, work, and day program environments, so that the clinicians can model how to appropriately use these strategies during the activities to expand and enhance staff's partnering skills as well as to expand and enhance active participation of the individuals via communication. • Also, collaborating with OT and PT in this capacity will further promote functional and meaningful activities for individuals. This provision continued to be in noncompliance. The clinicians did not have adequate knowledge and skills to conduct appropriate assessments, particularly in the area of AAC. The rationales applied to rule out AAC use were, at best, not consistent with generally accepted practices.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP	<u>Monitoring System</u> Monitoring of communication supports was provided (and documented) with the PNMP Monitoring form. These were used to evaluate staff knowledge regarding the required supports, the presence and condition of the supportive equipment, and the appropriate implementation of the supports. The frequency of this monitoring was not made clear to the monitoring team, but should be based on prioritized communication needs. Completed monitoring forms were requested related to communication for the month prior to the onsite review. It was reported that none had been completed and none were submitted. Three months of PNMP monitoring was also requested for the individuals included in the sample selected by the monitoring team. Only 14 forms were submitted for nine individuals and none were related to communication. Notations that no PNMP monitoring of any kind had been completed for 14 individuals (61%) of the sample. This was not acceptable based on the risk levels of the individuals as well as their communication needs.	Noncompliance

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	shall be reviewed and revised, as needed, but at least annually.	Monitoring findings were not documented in the individual record or integrated with the ISP review process. The SLPs did not reference these findings in their annual assessments or outline the necessary frequency of monitoring needed. Monitoring of communication programs and systems should be based on level of need related to 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. Evaluation of the frequency and consistency of implementation of communication supports and programs was another key indicator that was not reported. No tracking log for communication monitoring conducted over the last six months was submitted, so the frequency and consistency of monitoring by both the PNMPCs and SLPs could not be determined, but will be reviewed during the next visit by the monitoring team. This provision continued to be in noncompliance. There did not appear to be any system of monitoring conducted to ensure appropriateness of the communication supports provided and that they were implemented correctly and consistently.	

Recommendations:

1. The assessment format should differ between baseline, comprehensive and update evaluations if the facility is making a differentiation by naming them differently. If baseline is the initial assessment when an individual is first admitted, then issues related to why they were admitted, previous history or evidence of services should be reported, with testing that may need to be conducted. A comprehensive assessment may be completed at specified intervals such as three or five years and as such should address supports, services, health history and progress or changes over that period of time. Effectiveness of supports should be a key element. An update may be a more abbreviated report that addresses health and communication changes over the previous 12 months, outline supports and services, the effectiveness of these as well as findings from the monitoring conducted. The basic elements outlined in this report should be considered in the development of these assessment formats and content guidelines (R2).

2. Ensure that factors related to community placement are addressed for each individual that, minimally identify what supports and services would be needed for the individual when living in the community (R2).

3. Develop a system to conduct assessment audits to establish and maintain competency, form the basis for peer review and drive training and continuing education for the speech clinicians (R2).

4. Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal should be addressed in the communication assessment and reviewed routinely throughout the year (R2).

5. Assessment of AAC should take place over time and should be related to meaningful activities. Therapists should not consider that there are prerequisites to AAC use or that the hands are the only viable access to AAC. Switch use is not the only method (R2).

6. The clinicians should clearly describe communication abilities and opportunities across a variety of settings as observed by the therapist in the assessments. The daily activities should be observed for potentials for communication partners to facilitate participation. For example, encouraging an individual to look toward their wheelchair before a transfer or blinking or vocalizing for "go" to initiate the transfer are ways in which the individual can participate in a way that is communication-based. Holding a self-care object, like a toothbrush, while the DSP brushes their teeth is another way in which opportunities can be captured during routine activities throughout the day. These activities must be observed however to capitalize on those potentials. Clinicians must consider training and functional integration of AAC throughout the day as an option. Clinicians should include more opportunities for working with direct support staff and day program staff to model and coach ways to integrate communication and AAC throughout the day (R2).

7. Continue efforts to acquire full time SLPs to ensure that the facility is able to meet the identified needs of individuals and meet the requirements of the Settlement Agreement in a timely manner. Consideration of the addition of a Speech Assistant should be strongly considered as another means to provide training and coaching for appropriate implementation of communication plans (R1).

8. Support participation in continuing education opportunities related to communication for all SLPs (R1).

9. Develop guidelines and training for QDDPs as to how to integrate communication-related information into the ISP (R3).

10. Develop guidelines for documentation of communication supports and services to improve content and consistency (R4).

11. Evaluate content and instructional methods for NEO and other communication training (R3).

12. Monitoring of communication supports and services should be based on need. This should address the consistency of implementation and the effectiveness of these, in addition to condition of any AAC devices or systems (R4).

13. Develop an operational policy related to communication-related processes (R1).

14. 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).

15. Continued staff training and modeling are indicated to ensure appropriate and consistent implementation of recommended AAC systems (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 #67, Individual #489, Individual #284, Individual #198, Individual #557, Individual #442, Individual #537, Individual #550, Individual #264, Individual #69, Individual #310, Individual #39, Individual #17, Individual #276, Individual #305, Individual #484, Individual #10, Individual #592, Individual #378, Individual #377 o Skill Acquisition Plans (SAPs) for: • Individual #67, Individual #489, Individual #284, Individual #198, Individual #554, Individual #442, Individual #537, Individual #550, Individual #264, Individual #69, Individual #310, Individual #39, Individual #17, Individual #276, Individual #305, Individual #484, Individual #10, Individual #592, Individual #378, Individual #377 o Reviews of SAP progress for: • Individual #198, Individual #442, Individual #537, Individual #550, Individual #264, Individual #310, Individual #39 o Functional Skills Assessment (FSA) for: • Individual #198, Individual #557, Individual #264, Individual #310, Individual #377 o Personal Focus Assessment (PFA) for: • Individual #557, Individual #264, Individual #310, Individual #377 o Vocational assessments for: • Individual #198, Individual #557, Individual #264, Individual #310 o Dental desensitization plans for: • Individual #484, Individual #196 o Graph of engagement per home from March 2012-August 2012 o Section S Presentation Book, undated o Section S Self-assessment, dated 9/6/12 o Section S Action Plans, dated 9/6/12 o Education and Training Monitoring Form, dated 11/20/11 o Community Training Log from 9/11 to 8/12 o Graphs representing the occurrence of at least one community outing per home from 1/12-8/12 o A summary of community outings per home from 3/12-8/12 o A list of all instances of skill training provided in community settings from 9/11-8/12 o A listing of on-campus and off-campus day and work program sites, undated o A list of individuals who are employed on and off campus, undated o A summary of all treatment integrity checks, undated o Training materials used to teach staff to implement SAPs, undated

	o List of all individuals under age 22 and their current public school placement o ISPs, ARD/IEPs, and progress notes for: • Individual #10, Individual #360, Individual #591 <u>Interviews and Meetings Held</u>: o Barbara Shamblin, Director of Education and Training o Polly Bumpers, John Parks, Troy Miller, Bertha Allen, and Rodney Price, Unit Directors o Norvell Starling, MSSLC liaison to MISD <u>Observations Conducted</u>: o Desensitization Committee Meeting 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: Overall, MSSLC's self-assessment included some relevant activities in the "activities engaged in" sections that were the same as those found in the monitoring team's report. The monitoring team believes, however, that the self-assessment should include activities that are identical to those the monitoring team assesses as indicated in this report. For example, S1 of the self-assessment included a review of SAPs and engagement, which are topics that are included in the monitoring team's review of S1. Not all activities described in the self-assessment, however, were consistent with what the monitoring team reviewed. For example, S1 of the monitoring team's report also addressed the need for a clear rationale, a plan for generalization and maintenance, the training methodology, and desensitization plans, which were not addressed in the facility's self-assessment. The monitoring team suggests 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, and the monitoring teams report. 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 facility's 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 suggests that the facility establish, and focus its 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 no items of this provision of the Settlement Agreement were found to be in substantial compliance, the monitoring team noted improvements since the last review. These included: • Increase in the number of SAPs that included a rationale that clearly stated how acquiring this skill was related to the individual's needs/preference (S1) • Initiation of an interdisciplinary team to develop plans to decrease dental/medical sedation (S1) • Expanded collection of SAP treatment integrity (S3) The monitoring team suggest that the facility focus on the following over the next six months: • Ensure that each SAP has a plan for maintenance and generalization that is consistent with the definitions below (S1) • Collect relevant data regarding the educational services received by MSSLC individuals (S1) • Document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) • Review the treatment integrity tool to ensure it reflects both accurate implementation and documentation of SAPs, identify target levels of integrity, and insure the achievement of those levels (S3) • Ensure that measures of skill training in the community are accurate, establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved (S3)

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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,	This provision item required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at MSSLC. Although there had been progress since the last review, as indicated below, more work is needed to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance. Specific recommendations are detailed below. <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 that were written and monitored by eight master teachers. At the time on the onsite review, the terminology for these plans was changing from specific program objectives (SPOs) to	Noncompliance

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	to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Skill Acquisition Plans (SAPs). SAPs were implemented by education and training instructors and direct care professionals (DCPs). As discussed in the last report, an important component of effective skill acquisition plans is that they are based on each individual's needs identified in the 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. The monitoring team reviewed 110 SAPs across 20 individuals. In 91 of the 110 SAPs reviewed (83%), the rationale appeared to be based on a clear need and/or preference. This represented a dramatic improvement from the last review when all rationales reviewed were identical and, therefore, none of the SAPs appeared practical and functional. Examples of rationales that appeared to be based on a clear need and/or preference were: • The rationale for individual #67's vocational SAP of learning to use a tape measure indicated that he had an interest in working in construction, but could not use a measuring tape. • The rationale for Individual #550's SAP of brushing his teeth for two minutes was that he had poor oral hygiene because he did not consistently brush his teeth for a sufficient period of time. On the other hand, the following is an example of a rationale that was judged to not be specific enough for the reader to determine if it was practical and functional for the individual: • The rationale for Individual #310's SAP of selecting a coin from a group of similar objects was very generic and stated, "The following [SAP] was developed by (Individual #310) and his ISP team based on his FSA, Vocational Assessment, and Functional Work Behaviors Assessment." MSSLC should ensure that each SAP contains an individualized rationale for its selection. Additionally, the rationale should be specific enough for the reader to understand that the SAP 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	

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		• Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology The SAP training sheets contained all of the above components. As discussed in the last report, the maintenance and generalization plans, however, did not consistently reflect the processes of maintenance and generalization. A generalization plan should describe how the facility plans to ensure that the behavior occurs in appropriate situations and circumstances outside of the specific training situation. A maintenance plan should explain how the facility would increase the likelihood that the newly acquired behavior will continue to occur following the end of formal training. As found in the last report, all of the SAP 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 captured the essence of generalization as defined above, however, it did not specifically identify the activities that will represent generalization. For example, the generalization plan for an individual with a SAP 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 SAP could be "After mastering the use of the vending machine and the termination of the SAP, he will continue to make purchases in order to maintain this skill." It is recommended that all SAPs contain individualized generalization and maintenance plans that are consistent with the above definitions. As suggested in the last report, the facility attempted to expand the methodology for training of SAPs to forward (e.g., Individual #489) and backward chaining (e.g., Individual #557). It was not clear, however, from reading the task analysis or training instructions, that any of the SAPs that indicated the instructional method as backward	

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		training actually represented the correct use of backward chaining (i.e., guide the individual through the initial steps of the task analysis, and start training with the last steps of the task). It is recommended that the facility ensure that they are correctly using forward and backward chaining, and continue to attempt to expand the range of training methodologies. <u>Desensitization skill acquisition</u> MSSLC made progress in this area. Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures were developed by the psychology department. The psychology department had recently developed an assessment procedure to determine if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. This was good to see. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) was then developed. Since the last review, the facility established an interdisciplinary team to develop plans to decrease dental/medical sedation. A list of dental desensitization plans developed indicated that four plans were developed since the last onsite review. A review of two of those dental desensitization plans indicated that the plans were not in the new SAP format. It is recommended that dental compliance and dental desensitization plans be incorporated into the new SAP 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. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> As discussed in the last report, MSSLC included replacement/alternative behaviors in each PBSP. The training of replacement behaviors that require the acquisition of a new skill should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above. <u>Communication and language skill acquisition</u> SAPs for only one (Individual #305) of the 20 individuals reviewed (5%) had skill acquisition programs targeting the enhancement or establishment of communication and language skills. This represented a decrease in the number of communication SAPs at the facility from the last review when 10% of the SAPs 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 SAPs for individuals with communication needs (also see section R).	

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		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 Master Teachers. 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. 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 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. For example the monitoring team observed an example of 15 individuals playing flag football outside of L1, and 20 individuals playing bingo after dinner at the Rockin Robin Cafe. 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 continued to vary widely across staff and homes. The table below documents this variability across settings. The average engagement score across the facility was 64%, about the same as that observed during the last two reviews (i.e., 63% and 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 than the monitoring team's data. The self-assessment indicated that from 3/1/12 to 7/30/12 the average engagement score was 86%. In future reviews, the monitoring team will attempt to	

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		conduct engagement assessments with one of the active treatment monitors to better understand the discrepancy between the overall level of engagement reported by the facility and the monitoring team. Nevertheless, a review of engagement levels across homes and months indicated that the facility, similar to the monitoring teams data, reflected patterns of wide variation in engagement both across residential units, and across measures within the same unit. It is recommended that the facility review these trends in their engagement data, establish acceptable levels of engagement in each home, and attempt to achieve those levels of engagement. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
M1	3/5	1:5
M1	0/3	1:3
M3	3/6	4:6
M3	1/3	0:3
M4	4/4	3:4
M4	5/9	4:9
B1	2/4	4:4
B3	0/5	2:5
B5	4/6	3:6
B7 and B8	1/5	2:5
B7 and B8	0/2	1:2
Rockin Robin Cafe	20/20	5:20
C7	3/3	2:3
C7	2/3	2:3
W7	2 /3	7:3
W8	4/4	3:4
L3	3/3	2:3
S4	3/4	4:4
Woodshop	3/4	1:4
Small Workshop	5/7	4:7
Shredding Center	17/17	5:17
Step Center Classroom	7/7	3:7
Step Center Classroom	6/7	2:7

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		Educational Services The monitoring team again reviewed the ISD services provided to individuals at MSSLC who were entitled to educational services. A total of 68 students were receiving educational services from Mexia Independent School District (MISD). Since the time of the last review, the onsite MSSLC classrooms were closed and all students now attended school at MISD school buildings in town. Most were at MISD's special education building (59 individuals), but others were at the regular high school (9 individuals), or at the regular junior high school (no individuals, but some were likely to be transferred there). This was a major accomplishment for MISD and demonstrated how far the ISD had come in the two years since the monitoring team's baseline visit two years ago. This was primarily due to the efforts of the school district administration with support of the MSSLC liaison and facility management. MSSLC and MISD continued to have a good and collaborative working relationship. ARD/IEP objectives were included in the MSSLC annual ISPs and SAPs were developed for IEP objectives to foster continuity and activity when school was not in session. Information about MSSLC was included in MISD ARD/IEPs, and MSSLC staff attended ARD/IEP meetings (primarily Mr. Starling). The MISD ARD/IEP included re-integration plans for fostering students' greater inclusion into regular educational activities with non-MSSLC students. Further more, MSSLC assigned seven staff each day to work at the MISD classrooms to support the students and staff. The monitoring team was not able to determine if and how the IDT reviewed the MISD ARD/IEP progress reports. This should be occurring, however, it should not require a special meeting of the IDT. Mr. Starling should follow-up on this and ensure that it is occurring. Mr. Starling was also working with MISD on the way that in-school and out of school suspensions were handled. The monitoring team recommends that Mr. Starling collect some data on the frequency and duration (i.e., number of days) of in-school and out of school suspensions. Along these same lines, Mr. Starling should develop a set of indicators/data that reflect the status of the educational services received by individuals who live at MSSLC. He should work with the QA director on this. Some suggestions for data are below. These data might be presented to QAQI Council and PET as part of the section S quarterly and monthly reports. • Number of students attending MISD programs on the last day of each month • Percentage of MISD ARD/IEP objectives that are progressing (based on a sample of the most recent progress reports) • Number of in school suspensions each month • Average length of each in school suspension each month	

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		• Number of out of school suspensions each month • Average length of each out of school suspension each month	
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. This item was rated as being in noncompliance because, at the time of the onsite review, it was not clear that assessments were consistently used to develop SAPs. The facility had completed the transition from the use of the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA). The FSA appeared to be an improvement over the PALS in that it provided more information (e.g., necessary prompt level to complete the skill) regarding individual's skills. MSSLC also used the personal focus assessment (PFA) to assess preferences, and also a vocational assessment. The monitoring team reviewed six FSAs, five PFAs, and five vocational assessments. No assessment tool, however, is going to consistently capture all the important underlying conditions that can affect skill deficits and, therefore, the development of an effective SAP and set of SAPs. Therefore, to guide the selection of meaningful skills to be trained, assessment tools often need to be individualized. The FSA may identify the prompt level necessary for an individual to dress himself, but to be useful for developing SAPs, one may need to consider additional factors, such as context, necessary accommodations, motivation, etc. For example, the prompt level necessary for getting dressed may be dependent on the task immediately following getting dressed (i.e., is it a preferred or non-preferred task), and/or the type of clothes to be donned, whether the individual chooses them or not, etc. Similarly, surveys of preference can be very helpful in identifying preferences and reinforcers, however, there are considerable data that demonstrate that it is sometimes necessary to conduct systematic (i.e., experimental) preference and reinforcement assessments to identify meaningful preferences and potent reinforcers. For example Individual #377's PFA reported no preference for several areas (e.g., food, music). Systematic preference assessments have been demonstrated to be particularly effective in identifying preferences for individuals when surveys have not been useful. There was, however, no evidence of the use of a systematic preference assessment for Individual #377, or documentation of the use of any individualization of assessment tools to identify SAPs for any of the individuals reviewed. Additionally, it was not consistently clear, from a review of assessments and ISPs, how	Noncompliance

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		assessments impacted the development of SAPs. The following were typical: • Individual #198's FSA stated that he could independently combine coins and bills to equal five dollars. Nevertheless, he had a SAP to teach him to "combine coins and bills to equal a purchase price under five dollars." • Individual #264's vocational assessment indicated he consistently stayed focused on tasks with distractions, completed tasks independently, and was courteous, polite, friendly, trusting, and helpful to others. He had a SAP, however, to teach him to "…work without interfering with others..." • Individual #557 had a SAP to combine coins, but no mention in her ISP of any assessment results (e.g., FSA or PSA) that suggested that combining coins was a practical SAP for her. • Individual #377 had a SAP to discriminate coins, however no reason in her ISP, or assessments indicating why it was practical and functional for her to learn how to discriminate coins. The facility should ensure that assessments are consistently used (and their use documented) to select individual skill acquisition plans.	
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 made progress on this provision item. However, additional SAP outcome data and more information concerning how treatment integrity is conducted are necessary before this item can be rated as in substantial compliance. As discussed in previous reports, the master teachers at MSSLC graphed SAP data to improve data based decisions as to continuing, modifying, or discontinuing individual SAPs. Ten quarterly reviews (or three monthly reviews) were requested. Only three of the seven reviews received had at least three months of data. The other four reviews only included one month of data and, therefore, it was impossible to determine progress in order to assess compliance with this provision item. The three reviews (i.e., Individual #198, Individual #264, and Individual #310) with at least three months of SAP outcome	Noncompliance

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		data were reviewed and represented the outcome data of 20 SAPs. Seven of those SAPs (35%) indicated SAP progress. Given the small sample size it was impossible to determine if there was evidence of data based decisions concerning the continuation, modification, or discontinuation of SAPs. As during the last review, the implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. In one SAP observed (i.e., Individual #154's SAP of money management), the DCP appeared to implement the skill acquisition plan as written, however, she did not record the data following the completion of the SAP. When questioned, she indicated that she filled in everyone's SAP data later in the day. When data are not recorded as soon as possible after the task is completed, one increases the likelihood that those data will be inaccurate (see K4 for a discussion of the importance of recording data immediately after they occur). Nevertheless, the only way to ensure that SAPs are implemented as written is to conduct integrity checks. The facility collected SAP treatment integrity data. Treatment integrity consisted of a direct observation of staff conducting SAPs and one of the questions included "Is the SAP being implemented as written?" The self-assessment indicated that treatment integrity data were at 100%. The monitoring team was encouraged by the initiation of the collection of treatment integrity data, however, given the observation by the monitoring team and the large number of SAPs implemented daily at MSSLC, it appeared unlikely that every aspect of all skill acquisition sessions at the facility are implemented exactly as written. Future reviews will include the monitoring team observing some treatment integrity sessions too. In the meantime it is recommended that the facility review the treatment integrity tool to ensure it reflects both accurate implementation and documentation of SAPs. Additionally, it is recommended that the facility establish a schedule of SAP treatment integrity assessments, determine acceptable levels of treatment integrity, and provide performance feedback to staff to ensure that goal levels of treatment integrity are achieved.	
	(b) Include to the degree practicable training opportunities in community settings.	As discussed in the last review, the majority of individuals at MSSLC participated in various recreational activities in the community, and the facility appeared to be providing training opportunities in the community. In order to achieve substantial compliance with this provision item, the facility now needs to ensure that measures of skill training in the community are accurate, establish acceptable levels of recreational	Noncompliance

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		and training activities in the community, and demonstrate that those levels are consistently achieved. The facility was tracking the training of SAP objectives in the community. The director of education and training, indicated that those data may not have accurately reflected the implementation of skill acquisition programs in the community, and she was in the process of reviewing them more closely. Additionally, data provided the monitoring team indicated that the majority of individuals at MSSLC participated in community activities at least once each month. It is recommended that the facility now establish acceptable percentages of individuals participating in community activities and training on SAP objectives, and demonstrate that these levels are achieved. At the time of the review, no individuals at MSSLC had supported employment in the community. Nineteen individuals, however, worked in community enclaves. This was similar to the number of individuals working in the community during the last onsite review (20).	

Recommendations:

1. Ensure that each SAP contains a rationale for its selection that is specific enough for the reader to determine that it was practical and functional for that individual (S1).
2. All SAPs should contain individualized generalization and maintenance plans that are consistent with the above definitions (S1).
3. It is recommended that the facility ensure that they are correctly using forward and backward chaining, and continue to attempt to expand the range of training methodologies (S1).
4. Compliance and dental desensitization plans should be incorporated into the new SAP format (S1).
5. It is recommended that the facility expand the number of communication SAPs for individuals with communication needs (S1).
6. The facility should establish acceptable levels of engagement in each home, and attempt to achieve those levels of engagement (S1).
7. Ensure that MISD ARD/IEP progress reports are reviewed by the IDT (S1).
8. Collect data on relevant educational outcomes. Include these data in QAQI Council and PET presentations (S1).
9. The facility should ensure that assessments are consistently used (and documented) to determine individual skill acquisition plans (S2).

10. Graphed data summaries of individual SAP progress should be used to make data based decisions concerning the continuation, discontinuation, or modification of SAPs (S3).

11. Review the treatment integrity tool to ensure it reflects both accurate implementation and documentation of SAPs (S3).

12. The facility should establish a schedule of SAP treatment integrity assessments, determine acceptable levels of treatment integrity, and provide performance feedback to staff to ensure that goal levels of treatment integrity are achieved (S3).

13. It is recommended that the facility establish acceptable percentages of individuals participating in community activities and training on SAP objectives, and demonstrate that these levels are achieved (S3).

14. Revise the self-assessment so that it includes the topics that the monitoring team commented upon in the report (self-assessment).

15. Establish six-month goals to focus upon for the next onsite review (self-assessment).

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, updated 4/14/12, Admissions, 9/1/11, Placement Team Review, 9/15/11, and Placement Review and Appeals, 9/15/11 o MSSLC organizational chart, 9/1/12 o MSSLC policy lists, August 2012 o List of typical meetings that occurred at MSSLC, undated, likely August 2012 o MSSLC Self-Assessment, 9/6/12 o MSSLC Action Plans, 9/6/12 o MSSLC Provision Action Information, most recent entries 8/7/12 o MSSLC Most Integrated Settings Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/24/12 o Community Placement Report, last six months, 3/1/12 through 9/27/12 o List of individuals who were placed since last onsite review (28 individuals) o List of individuals who were referred for placement since the last review (37 individuals) o List of individuals who were referred and placed since the last review (0 individual) o List of total active referrals (50 individuals), as of 9/27/12 o List of individuals who requested placement, but weren't referred (85 individuals) • Documentation of activities taken for those who did not have an LAR (83 individuals) ▪ Spreadsheet with information regarding 29 individuals • List of individuals who requested placement, but weren't referred due to LAR preference (2 individuals) o List of individuals who were not referred solely due to LAR preference (same 2 individuals) o List of rescinded referrals (1 individual) • ISPA notes regarding each rescinding • Special Review Team minutes for each rescinding o List of individuals returned to facility after community placement and related ISPA documentation (0 individuals returned during this period) 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, and a brief narrative for each case (nothing submitted to monitoring team) o List of individuals who died after moving from the facility to the community since 7/1/09 (16

	individuals, 4 since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (17 individuals) o APC weekly reports • Statewide weekly enrollment report, four, 8/17/12 through 9/7/12 • Detailed referral and placement report for senior management (none) o Job descriptions for APC, PMM, and transition specialists o Training handouts for ISP training sessions by Jim Sibley, July 2012 o ISP Process Recommendations from Consultant, MSSLC management review meeting, 7/26/12 o Information and emails regarding statewide APC trainings held in June 2012 o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, June 2012 ▪ Announcements, attendance sheets, evaluation information and summaries • Community tours, 3/23/12 through 8/24/12 (11) and staff notes from 9 of the tours • Meetings with local LA (3), 4/12/12, 5/22/12, 7/27/12 • New employee orientation (none) • Sessions with facility staff: QDDPs, 8/10/12 • Self-advocacy meeting (none) • Family association meetings (none) • Facility newsletter, information on admission and placement (1) o Description of how the facility assessed an individual for placement (state policy) 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), and any obstacles, undated o List of individuals who had a CLDP completed since the last review (30 individuals) o Completed checklists used by APC regarding submission of assessments for CLDP that were <u>not</u> within the CLDP, and completed checklists (8 examples) o Training session for clinical staff regarding 45-day timeline, 7/11/12 o Essential/nonessential supports guidance sheet, undated, 1 page o DADS central office written feedback on CLDPs (2 individuals) o Section T presentation materials and graphs, for QAQI Council, 7/19/12 o For the three statewide monitoring tools for section T: (none) o Community placement obstacles listing, 3/1/12-9/6/12, and 9/1/11-7/24/12 o State obstacles report and MSSLC addendum, October 2011 o PMM tracking sheet, 9/27/12 o Transition T4 materials for: • 17 individuals o ISPs and assessments in the older styles for: • Individual #157, Individual #287, Individual #451, Individual #446, Individual #325 o ISPs in the September 2012 style for: • (none) o CLDPs for:

	• Individual #32, Individual #572, Individual #181, Individual #578, Individual #379, Individual #249, Individual #461, Individual #199, Individual #548, Individual #75 o Draft CLDP for: • Individual #221, used during his CLDP meeting o In-process CLDPs for: • Individual #557, Individual #520, Individual #196 o Pre-move site review checklists (P), post move monitoring checklists (7-, 45-, and/or 90-day reviews), and ISPA documentation of any IDT meetings that occurred after each review, conducted since last onsite review for: • Individual #32: P, 7 • Individual #254: P, 7 • Individual #391: P, 7 • Individual #141: P, 7 • Individual #379: P, 7 • Individual #199: P, 7, 45 • Individual #359: P, 7, 45 • Individual #249: P, 7, 45 • Individual #394: P, 7, 45 • Individual #548: P, 7, 45 • Individual #453: P, 7, 45 • Individual #234: P, 7, 45, 90 • Individual #165: P, 7, 45, 90 • Individual #354: P, 7, 45, 90 • Individual #75: P, 7, 45, 90 • Individual #131: P, 7, 45, 90 • Individual #405: P, 7, 45, 90 • Individual #44: P, 7, 45, 90 • Individual #167: P, 7, 45, 90 • Individual #95: P, 7, 45, 90 • Individual #564: P, 7, 45, 90 <u>Interviews and Meetings Held</u>: o Alynn Mitchell, Admissions Placement Coordinator o Sarah Ham, Post move monitor, Jeanette Reaves, Transition Specialist o Dianne Thomas, DADS state office community placement staff o Community provider agency, A-Trinity, Alan Gould, owner, Darren Bolton, Janeesha Houser, residential manager and staff <u>Observations Conducted</u>: o CLDP Meeting for: • Individual #221

	o CLDP assessment review meeting for: (none) o ISP Meeting for: • Individual #151 o ISP preparation meeting for: • Individual #94, Individual #441 o Community group home and community day program visits for: • Individual #32 o Self-advocacy meeting, 9/25/12
	Facility Self-Assessment The APC and PMM had further developed what was presented last time by including a variety of activities in the self-assessment. In that regard, they made progress in that she was trying to look at actual activities and outcomes for each provision item. The monitoring team and the APC and PMM spoke at length about the self-assessment during the onsite review. The self-assessment, however, focused almost exclusively on the results of a small sample of statewide self-monitoring tools. As noted throughout this report and in previous reports, there were many problems with these tools. Therefore, basing the self-assessment on an invalid tool means that the results of the self-assessment are likely to be (and often were) incorrect. The APC, therefore, needs to develop tools that are valid and that also line up with the content of what is in the monitoring team's report. This should not be difficult to do. She should go through the report and make an outline of everything that the monitoring team comments upon in each provision item. For example, in T1a, the APC used the living options monitoring tool for item 1. A reading of section T1a in the monitoring report shows that there were many topics reviewed by the monitoring team that were not in the APC's tool. For item 2, however, she looked at demographic data in a similar manner as did the monitoring team. The self-assessment for T1b incorrectly stated that the T1b rating was a function of the ratings received for T1b1, T1b2, and T1b3. This was wrong as evident by reading the monitoring team's comments in T1b. In T1b1, items 6 and 7 were closer to the kinds of items that will be more helpful to the APC. T1b2 should contain items for all nine of the topic areas described in the report (and in previous reports). In T1b3 in the report, four topic areas were addressed regarding occurrence and quality of living option discussions, but the self-assessment only commented upon whether a living options discussion occurred. T1d was rated in substantial compliance by both the monitoring team and the APC. The APC's self-assessment, however, did not (but should) include all of the aspects of the CLDP assessment process that were reviewed by the monitoring team.

	Similar to T1b, the rating of T1c was incorrectly considered by the APC to be a function of T1c1, T1c2, and T1c3. Instead, what is clear to the reader of T1c, T1c1, T1c2, and T1c3 is that all four of these provision items contain different content. As a result, the APC incorrectly rated T1c and T1c1 as being in substantial compliance when they were not. For T1e (one of the most important provision items in section T), the APC self-rated substantial compliance because she only considered whether any essential and nonessential supports existed in the CLDP whereas the monitoring team strongly assessed whether a full set of ENE supports were included as well as the quality of the list of ENE supports. It looked like the APC did a nice job of self-assessing T2a. The monitoring team recommends that a self-assessment for T2b (implementation of post move monitoring) be done, too. For T4, the monitoring team did not consider the content of the discharge reports to be adequate, especially the quality of the set of recommendations for the individual's next home. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the APC and believes that the facility was continuing to proceed in the right direction.
	Summary of Monitor's Assessment MSSLC continued to make progress across all provision items of section T. The number of individuals placed was at an annual rate of more than 15% (28 since the last onsite review). Approximately 14% of the individuals at the facility were on the active referral list, that is, 50 individuals. There was progress in placing individuals who had been on the referral list for a long period of time, as evidenced in the reduction of the number of individuals on the referral list for more than 180 days and for more than one year. Further, individuals were being placed from all five units. Of the 21 individuals who received post move monitoring that was reviewed by the monitoring team, 20 (95%) transitioned very well and appeared to be having great lives. One appeared to be going through some transition problems that were, perhaps, not being adequately addressed by his provider. The high percentage of individuals who had a good transition and who were having good lives in the community demonstrated ongoing efforts by the admissions and placement staff and by the IDTs to continually improve the referral and placement process at MSSLC. Since the last review, four individuals had died since being placed. The APC should do a review of any and all of these cases. Similarly, 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, who had run away from their community placements, and/or had other untoward incidents were not being kept, but should be, for at least a one-year period after moving. Determinations of professionals regarding referral for placement and transition were not yet being made

	or included in the ISP process. The preferences of individuals, however, continued to be sought and met by MSSLC IDT members. IDT members were very involved in the placement activities of the individuals. Team members thoughtfully evaluated the homes and day programs being explored by the individual. Obstacles to referral and to placement need to be appropriately identified and there should be an action plan to address whatever obstacles were identified. MSSLC was engaging in some, but not all, of the activities required to educate individuals, LARs, family members, and the MSSLC staff about community living options. Overall, the quality of the CLDPs had improved. A CLDP meeting was held during the onsite review. It was the best CLDP meeting yet observed by the monitoring team. MSSLC also made further improvements in the assessments prepared for each CLDP. There was continued improvement in the development of the list of essential and nonessential supports, however, more improvement was needed. Improvements were need to ensure the inclusion of every important aspect of MSSLC plans (e.g., PBSP, PNMP, dining plans), the individuals' desires to be employed, and skill acquisition plans. Further, all preferred activities and items should not be put into one single ENE support. The APC (or transition specialist or PMM) should do an ENE support self-assessment prior to finalization of the list of ENE supports. There was no organized, easily explained quality assurance process as required by this provision item. The APC, and other staff in the department, appeared to use the statewide self-monitoring tools regularly. The monitoring team's comments regarding these tools from previous monitoring reports in sections T1f and E remain applicable and should be reviewed by the APC. Since the last review, 55 post move monitorings for 27 individuals were completed. This compared to 38 post move monitorings for 16 individuals at the time of the last review. Post move monitoring occurred all over the state. The APC and her staff must attend to the items bulleted in T2a regarding there being a high quality post move monitoring review document completed by all staff who conduct post move monitoring, and ensuring that all follow-up efforts are thoroughly documented and detailed. The discharge reports were improved from the time of the last review, however, the important last section of the report, regarding referrals and/or necessary services required in new environment was not adequate in almost every report.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	MSSLC continued to make progress across all provision items of section T. This was due, in large part, to the attention paid by the staff to the previous monitoring report, consistent staffing in the admissions and placement department, and the regular collaborative constructive feedback that the staff reported they provided to one another. In addition, one transition specialist was added to the facility. The specific numbers of individuals who were placed and who were in the referral and placement process increased somewhat, but appeared to remain manageable. The number of individuals placed was at an annual rate of more than 15%. Approximately 14% 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. • 28 individuals had been placed in the community since the last onsite review. This compared with 17 individuals, 25 individuals, 23 individuals, and 63 individuals who had been placed at the time of prior reviews. o This showed a relatively stable and manageable trend of about one placement per week, on average. • 37 individuals were referred for placement since the last review. This compared with 21, 27, 18, and 44 individuals who had been referred at the time of the last reviews. o This was the highest number in two years and indicated that IDTs were taking seriously their responsibility for making referrals. The APC should keep a close watch of this number to ensure that she has the resources to adequately manage the activities required. ▪ If the rates of placement and of referral continue, the number of individuals awaiting placement will grow. ▪ Even if individuals are referred at a higher rate, MSSLC must still ensure that placements are planned thoughtfully and that as much time is taken as is needed so that placements have a high likelihood of success. ▪ The facility should be very cautious about not repeating some of the errors in transition planning that were found and reported in the baseline and compliance monitoring reviews in 2010. At that time, however, there were only two staff in the department and there was less policy and procedure to guide the staff in properly placing individuals. o Of these 37, 0 individuals were both referred and placed since the last onsite review.	Noncompliance

		• The total number of individuals on the active referral list was 50 at the time of this review. It was 42, 49, and 73 at the time of the previous reviews. o 9 of the individuals lived on the Whiterock unit, 6 lived on Longhorn, 8 lived on Shamrock, 12 lived on Barnett, and 14 lived on Martin. o 14 of the 50 individuals were referred for more than 180 days. This compared with 26 individuals at the time of the last review. ▪ 3 of the 14 were referred more than one year ago. This compared with 5 at the time of the last review. o The post move monitor created and maintained a spreadsheet that tracked the activities/dates regarding each of the active referrals. The comments column was very helpful in providing a short phrase about the status each one, such as CLDP pending, provider chosen, etc. • 85 individuals were described as having requested placement, but were not referred. This compared with 157, 160, 168, and 40 individuals at the time of the previous reviews. o When asked why the number was about half of what it had been, the APC said that it could be that now, compared with the time of previous reviews, the absence of the LA at the meetings was no longer an obstacle, psychiatric and behavioral issues were more under control, and the identification of obstacles and supports had improved. o Of these, 2 were listed as not being referred solely due to LAR preference. This compared to 9 and 67 at the time of the last reviews. o The most often listed reason for not being referred was behavior/psychiatric (19 of 29 individuals). o There was little documentation of activities taken for those who did not have an LAR (i.e., 0 of 83 individuals) ▪ The APC and post move monitor made a spreadsheet that listed some of the individuals (29 of the 83) and the facility's actions. The spreadsheet contained the discussion date and an ISP action plan sentence. Typically it said, "To receive support to overcome obstacles to a successful community integration." For 11 of the 29, the facility response information was blank. ▪ 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. • The list of individuals not being referred solely due to LAR preference contained 2 names. This compared with 9 at the time of the previous review. 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 referral of 1 individual was rescinded since the last review. This compared	

		with 7 and 20 individuals whose referrals were rescinded at the time of the previous reviews. o The 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 the rescinded referral and made relevant comments. o The referral was rescinded due to escalations in serious problem behaviors by the individual. o Follow-up occurred regarding the four individuals whose referrals were rescinded at the time of the last review due to the provider being unable to proceed. At this time, two of the four had been re-referred. The other two were not re-referred due to health issues. o As recommended in previous reports, however, the APC should do a detailed review (i.e., root cause analysis) of each of rescinded case to determine if anything different could have been done during the time the individual was an active referral. Note that the ISPA and the SRT notes provided a lot of detail regarding the decision to rescind. The purpose of the APC review is to assess the referral and placement processes. o Note, moreover, that the new ISP process may result in an increase in referrals and, as a result, an increase in the number of rescinded referrals. If this occurs, it should not necessarily be viewed as an increase in failure by the facility. • 0 individuals returned to the facility after community placement. This compared with 1 and 0 individuals at the time of the previous reviews. • 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, who had run away from their community placements, and/or had other untoward incidents were not provided. These data should be obtained, for at least a one-year period after moving. o These are very important data, especially given the population being placed by the facility. o Any incidents in the future, a detailed review/root cause analysis should be conducted for any significant post-move events in order to assess the referral and placement processes. • 4 individuals had died since being placed since the last onsite review. This compares with 0 at the time of the previous 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>three</u> monitoring reports, but had not been addressed by the facility.	

		• 17 individuals were discharged under alternate discharge procedures (see T4). As recommended in previous monitoring reports, each of the above bullets should be graphed separately. There was some progress in that a variety of graphs were submitted. The monitoring team recommends creating simple line graphs with one data point representing one month of data. These data/graphs 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. Further, the APC and PMM requested that the monitoring team provide a list of the graphs that it recommends be created. Once the database or spreadsheet is set up, it will not take much time each month to enter these data and print out the graphs. The printouts should have more than one small graph on each page (e.g., four) to make the set of graphs easier to manage for the reader. • Number of individuals placed each month • Number of new referrals each month • Number of individuals on the active referral list as of the last day of each month • Number of individuals on the active referral list for more than 180 days, as of the last day of each month • Pie chart showing the status of all of the active referrals. This pie chart can be created when needed, such as for the PET and QAQI Council presentations, to submit to the monitoring team, etc. • Number of individuals who have requested placement, but have not been referred, as of the last day of each month. • Percentage of individuals who have requested placement (who do not have an LAR), but have not been referred, for whom a placement appeal process has been completed, as of the last day of each month • Number of individuals not referred solely due to LAR preference as of the last day of each month • Number of individuals whose referral was rescinded each month • Number of individuals returned to the facility after community placement each month • Number of individuals who had any untoward event happen after community placement each month • Number of individuals who died after community placement since 7/1/09 each month • Number of individuals alternately discharged (T4) each month • From T1b1 below: number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles	

		• From T1b2 below: number of individuals who went on a community provider tour each month <u>Other activities</u> None described. <u>Determinations of professionals</u> This aspect of 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 was discussed at length in previous monitoring reports. Primary responsibility for meeting this requirement belongs to the ISP Facilitators, the QDDPs, and the professionals. Thus, the monitoring team looks for indications in each professional's assessment, during the conduct of the annual ISP meeting, and in the written ISP that is completed after the annual ISP meeting. Overall, the MSSLC ISPs included comments that those referred had demonstrated and maintained improvements in behavior problems for a period of time, often a year or more. MSSLC was transitioning to the newest iteration of the ISP process (see section F). As a result, the monitoring team was limited in its ability to review professional determinations. During the week of the onsite review, the first new style annual ISP meeting was held. The monitoring team observed this meeting. The completed ISP document, however, was not completed (it was not due for 30 days after the meeting). As a result, the monitoring team used its observation of this one annual ISP meeting and of two third-quarter ISP preparation meetings, and a review of a sample of ISP documents completed for three annual ISP meetings held in April 2012 and one meeting held in July 2012. The monitoring team understands that the content and processes used in these ISP meetings and documents were to be updated. Nevertheless, the monitoring team provides some comments below and in section T1b1 and T1b3. First, for the written assessments, professional determinations were not regularly in any assessments other than in the nursing assessments. Adding a prompt to all of the assessments would be one way to improve this. Second, in the ISP meeting and ISP preparation meetings observed during the week of the onsite review, community living was discussed at various times during the meeting, but professionals were not asked to give their opinions. The monitoring team, however, has found this one-by-one verbal statement from each member of the IDT to be of value in the ultimate decision-making of the entire IDT. The monitoring team remains open to	

		further discussion with DADS and the DADS consultant regarding this component of the ISP meeting. In observations and reviews at MSSLC and the other SSLCs, the monitoring team has noted different "approaches" to way professionals give their determinations and opinions. The monitoring team recommends that the facility and state office consider providing more direction to the professionals, so that there is a consistent approach to this requirement. It may be that all three of these aspects of the professional's opinion should be addressed (that is the recommendation of the monitoring team). 1. A description of what supports that individual would need if he or she lived in the community. This, alone, was not really an adequate indication of the professional's opinion. 2. A statement of whether needed supports could be provided in the community, based upon the professional's knowledge of available community supports. 3. A specific declarative statement regarding whether the professional believed the individual should be referred and whether the individual was likely to do well in the community. <u>Preferences of individuals</u> The preferences of individuals continued to be sought and met by MSSLC IDT members. Practices continued, such as individualizing the search for appropriate providers. IDT members continued to visit homes and day programs that were being considered for each individual who was referred, prior to placement. Individual and LAR preferences for specific locations in the state were usually met by the IDTs. <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 the weekly statewide enrollment report. Senior management, however, would benefit from more detail about the status of referrals, placements, and lifestyles/successes of some individuals who had transitioned. To that end, the monitoring team recommends that the APC consider completing a weekly report much like the completed by the Lufkin SSLC APC, and that she do an occasional verbal presentation (e.g., once per month), perhaps at the Tuesday executive management meeting.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two	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	Noncompliance

	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:	revision was completed and the DADS state office was expecting to disseminate it very soon. As noted in previous reports, on 5/16/11, the three monitoring teams submitted a number of comments related to the DADS draft policy for the state's consideration. It was anticipated that the state would address the monitoring teams' concerns in the revised version of the policy. MSSLC had approved and implemented a facility-specific policy Most Integrated Setting and the Community Living Process, CM#12. It was slightly updated on 4/12/12. It may need to be revised or perhaps totally re-written once the new state policy is finalized and disseminated. Further, at the parties' meetings in July 2012, the parties agreed that the rating for T1b would be based solely on the development of adequate state and facility policies. The sections T1b1 through T1b3 would be considered stand-alone provisions that required implementation independent of T1b or any of the other provision items under T1b. The state and facility had not yet finalized adequate policies related to most integrated setting practices, therefore, the facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The newest style ISP process described in the previous report had been brought to MSSLC, but was only implemented for the first time during the week of this onsite review. The new ISP was to include items that had been missing from previous ISP formats, such as professional's opinions (T1a), the identification of protections, services, and supports (T1b1), the identification of individual obstacles (T1b1), and a thorough living options discussion and determination (T1b3). <u>Protections, Services, and Supports</u> The reader should see sections F and S of this report regarding the monitoring team's findings about the current status of ISPs and the IDT's ability to adequately identify the protections, services, and supports needed for each individual. Recently, DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was also found for these three provision items of section F: F1d, F2a1, and F2a3 The 10 CLDPs reviewed by the monitoring team indicated that no special actions were taken after an individual was referred to ensure that skill acquisition programs were considered and developed based upon the individual's referral to the community. The monitoring team recommends that, upon referral, the APC and/or transition specialist seek out the IDT, and the active treatment coordinator to talk about what SAPs might be	Noncompliance

		considered now that the individual was referred for placement. This should be documented in the CLDP. If this type of discussion occurred during the ISP meeting in which the individual was referred, it should be explicitly documented in the ISP, too. The APC reported that this was beginning to happen, but the monitoring team could find no evidence of it (also see sections F and S). There were, however, many SAPs that included, in the rationale, that the individual wanted to live in the community, and that because of this, they were going to teach the individual to do laundry, learn community signs, etc. <u>Obstacles to Movement</u> Given that a new iteration of the ISP was just underway, the monitoring team's ability to comment on this aspect of this provision item is extremely limited. Going forward, the facility should ensure that obstacles to referral and to placement are appropriately identified and included in the new ISP (the ISP template format included this). Further, there should be an action plan to address whatever obstacle or obstacles were identified. The monitoring team recommends that the next revision to the facility's self-monitoring tool for section T contain a determination of whether the ISP showed that the IDT identified obstacles to referral and placement, and if the ISP included a plan to overcome any identified obstacles. These data could then be incorporated into the data set described in T1a above.	
	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.	Below are the nine activity areas upon which the Monitors, DADS, and DOJ agreed would comprise the criteria required to meet this provision item. The solid and open bullets below provide detail as to what is required. MSSLC was engaging in some, but not all, of these activities. The APC and PMM reported that they felt they were starting to address five of the nine activities. It was good to see that they were attending to the details of this provision item. <u>1. 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>: There was some progress towards developing an individualized plan in that the newer ISPs described activities the individual and/or LAR would take over the upcoming year, such as visiting some community providers. All three of the above open bullets, however, were not included in any of the ISPs. This may require an additional prompt in the ISP or standard expectations about what is in an action plan for community living.	Noncompliance

		2. Provider fair • 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 MSSLC status: The APC made progress regarding the provider fair. The fair was held in early June 2012. It was announced with fliers posted and with articles in the facility newsletter. Two sessions were held, one for the Martin and Barnett units, the other session for the other three units. This was a good idea. Data were kept on whether each individual attended. Results showed 46% of the individuals attended, compared with 58% in 2011. Evaluations were completed by about 30 respondents. Overall, the responses were positive with some suggestions for future fairs. Data were summarized. During the next onsite review, the APC and PMM should report on what they were planning for next year's provider fair and how the data and responses received this year affected what is planned for next year. 3. Local MRA/LA • Regular SSLC meeting with local MRA/LA MSSLC status: The APC maintained a good working relationship with the local authority. Three meetings occurred since the last review. These were two quarterly meetings (April 2012, July 2012) and one was a presentation by the APC to the group (May 2012). 4. 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 LA CLOIP workers. 5. 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: There was progress and improvement since the last onsite review in	

		arranging tours and having individuals and staff participate. Since the end of April 2012, it appeared that three or so tours occurred every month. For each tour, the staff attending completed a detailed one-page report of each individual's participation and reaction to the tour. Thirty-seven individuals attended 11 tours. There were no reported problems with transportation or staffing that delayed or cancelled tours. This was all good to see and a step in the right direction. To move forward, there needs to be: o The report/form information needs to go the IDT, so that it could be used by the team for planning purposes o A tracking system so that the APC knows if all individuals for whom a tour is appropriate indeed went on a tour. 6. Visit friends who live in the community MSSLC status: MSSLC was not yet implementing this activity in any organized manner. 7. 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 rights officer was new to her role and was working on improving attendance and participation. There were weekly house meetings. It did not appear that community living education was often a topic. No other educational activities were described or reported. The activities noted in the previous report did not appear to have continued. 8. A plan for staff to learn more about community options • management staff • clinical staff • direct support professionals MSSLC status: There was no plan to address this item. The APC, however, reported that she and her staff presented and participated in an all day QDDP training session on 8/10/12. The relevant topics to section T were CLOIP, obstacles to referral and placement, and the CLDP procedures. A plan to address this item should also include new employee orientation, periodic meetings with the discipline departments and the QDDPs, and periodic emailing of policies and other announcements to management and clinical staff. The activities noted in the previous report did not appear to have continued.	

		9. 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 APC presented the state policy on most integrated settings and a list of all individuals at the facility along with their referral status. 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 No further progress was found. At MSSLC, QDDPs in particular need to be sure to review the reason for each individual's placement at MSSLC to ensure that all proper legal requirements regarding their placement have been, and are being, fulfilled. If so, they should advocate for referral, as appropriate. • 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 occurring at MSSLC. • Living options for the individual were thoroughly discussed during the annual ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. o This was somewhat more evident during three observations. First, at Individual #151's annual ISP meeting, his IDT reviewed that he had lived at MSSLC for 50 years, but given that it was becoming a forensic facility, they wanted to explore other options. They discussed the Abilene area because his brother lived near there and requested that he be closer, if possible. Community living, however, was ruled out due to his need for a respiratory therapist on staff. Therefore, the Abilene SSLC was discussed and there was agreement to refer him there. It was good to see the IDT discussing this, however, it was not clear if the ability of a community provider to support him was fully explored. o Second, one ISP preparation meeting was for Individual #94, who was already referred. The IDT discussed the status of his referral, the provider who had been chosen, and his upcoming pre-placement visit. o Third, the discussion of community referral for Individual #441 was not	Noncompliance

		thorough. There were references at different times during the meeting to some time in the future when he may be ready for referral, when his behaviors are improved, and what he needed to do. • 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 Although there were statements at the end of the ISP, in a section titled Living Option Determination, these were not yet written adequately or in enough detail.	
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:	The APC reported that 30 CLDPs had been completed since the last review. The monitoring team reviewed 10 of the most recent of these CLDPs (33%). A set of in-process CLDPs was also reviewed. Across the 30 CLDPs, there were individuals from all five units. Further, CLDPs were developed, and individuals were placed, from the Whiterock unit. This was an improvement from the last review when no individuals from the Whiterock unit were placed and when the largest number individuals on the referral list were from Whiterock (because they were not being placed). This was no longer the case (see T1a). Overall, the quality of the CLDPs had improved. It is likely that substantial compliance can be achieved in the near future with further improvements as noted in sections T1c, T1c1, and T1e below. <u>Timeliness</u>: Many of the individuals were on the referral list for longer than 180 days. Even so, a CLDP could still be considered to be timely because there are many reasons for delays that are not due to lack of activity by the APC, IDT, or provider. For instance, DADS terminated its contracts with two community providers. In those cases, a number of months of work were lost and a new provider (or set of possible providers) had to be identified and examined. In many other cases, however, there were long gaps (i.e., months) where it was not clear what, if anything, was occurring regarding the referrals. The CLDPs included monthly paragraphs describing the status of any referral that was older than 180 days, however, many of these merely stated that the individual's referral remained active. To meet this aspect of this provision item, as noted in the previous report, the CLDP needs to clearly state why there were gaps in activity regarding the individual's referral. Note, however, that the admissions and placement staff were making progress in placing individuals who had been on the referral list for a long period of time, as evidenced in the reduction of the number of individuals on the referral list for more than 180 days and for more than one year (see T1a).	Noncompliance

		Initiation of the CLDP: Rather than waiting until right before the individual moved, the CLDP document should be created at the time of referral. This was now occurring at MSSLC, usually 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. The CLDP contents were then developed and completed over the months during which referral and placement activities occurred. All individuals on the referral list were reported to have a CLDP. The monitoring team recommends that the APC include (i.e., add) the date of initiation of the CLDP on the front page of the CLDP. This would be in addition to the four important dates already on the CLDP (date of admission, date of referral, date of CLDP, and date moved to the community). A sample of the in-process CLDPs were reviewed. They were for referrals that occurred approximately 30, 90, and 120 days. Very little information was in all three of these CLDPs. The in-process CLDPs did not demonstrate that CLDPs were developed over the course of the individual's referral. IDT member participation: IDT members were very involved in the placement activities of the individuals. Team members thoughtfully evaluated the homes and day programs being explored by the individual. This occurred at MSSLC with guidance from the admissions and placement staff. IDT members discussed possible providers, supported individuals on exploration visits (usually multi-day overnight visits), reviewed the individual's experiences, visited residences and day sites themselves, and actively participated in the choice of provider. CLDP meeting prior to move: The CLDP meeting for Individual #221 was observed by the monitoring team. This was the best CLDP meeting yet observed by the monitoring team. Clearly, the transition specialist, Jeanette Reaves, and the post move monitor, Sarah Ham, responded to the recommendations and comments made in the previous report and during the previous onsite review. Overall, the meeting was lively, participation from all attendees was very good, time was not wasted, important topics were covered, and the meeting lasted a very manageable 90 minutes. To be more specific, the transition specialist did not waste time by reviewing information that everyone already knew, that is, she began the meeting by discussing the day of his actual move (one of the most exciting parts of the meeting for most individuals). From there, she addressed some of the details of the move, potential issues with the public school, the IDT member who would accompany the placement staff for the pre move site review, and so forth. She engaged the individual as appropriate and called upon direct care staff as appropriate. As recommended in the previous report, she did not let the	

		flow of the meeting get bogged down due to the need to complete certain paperwork aspects of the CLDP form. The transition specialist and post move monitor reported that they worked together over the past six months to improve the CLDP meeting. Fortunately, due to the number of referrals and placements, there was frequent opportunity to do so. The post move monitor participated in each CLDP meeting, but also provided specific feedback to the transition specialist (regarding, for example, length of meeting, participation by attendees, identifying evidence for the ENE supports). This system of direct observation and feedback was an excellent idea and is recommended for any other transition specialists who may begin to lead CLDP meetings. The monitoring team recommends that that transition specialist do some preparatory work with the individual and with the direct care staff prior to the CLDP meeting so that they know what to expect and so that they know what participation is expected from them. For example, the CLDP contained a two-page questionnaire completed by the individual regarding his preferences. This could have been used to help the individual and the direct care staff prepare and then participate in the meeting in a more efficient and effective manner. <u>Post post-move monitoring IDT meetings</u>: IDT meetings continued to occur after every post move monitoring visit, even if there were no problems. Please also see T2a.	
	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.	Ten CLDPs developed and completed since the last onsite review 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 LA and community provider. Some comments regarding the actions in the CLDP are presented below. • The CLDPs did not adequately identify the need for training for community provider staff. The CLDPs did not include good descriptions of the content of what was to be trained. To move forward with this aspect of this provision item, the APC should address the following: o All of the specific community provider staff who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff) were not identified. o The method of training was not indicated, such as didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or NCP. o The training often stated that it was competency based. It also needs to state how competency was to be assessed. ▪ This seemed especially important given some of the training	Noncompliance

		topics, such as the need for rectal diastat if a seizure lasted longer than a predetermined amount of time. • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. This was especially important given the challenging histories of most of the individuals placed and due to the importance that clinical services played in the individual's success at MSSLC. Examples included counseling, psychiatry supports, and functional assessments as part of PBSPs. For example, treatment at MSSLC included programs called STOP, STARS, Stop-Think-Go, and individualized point systems. These program components were described as having played a very important role in the individuals' success (e.g., participation, absence of problem behaviors) and can not easily be understood by a community clinician by merely reading the CLDP and PBSP. • The monitoring activities of the local authority, as well as the role of facility staff in the post-move monitoring and follow-up process were described in standardized sections of the CLDP. There were not, however, any action steps designed to ensure that the post move monitor worked together with the LA Service Coordinator by keeping him or her informed of the status of essential and nonessential supports and/or any other important aspects of the individual's home and work life found by the post move monitor. • 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. The assigned staff person was now included, which was good to see. The completion of these activities also needs to be documented. DADS central office continued to conduct reviews of CLDPs at MSSLC. Feedback was given for the two CLDPs. One was for an individual who moved in March 2012, the other for an individual who moved more recently, in August 2012. The reviews were well done and thorough. The content was relevant and important. It is unlikely, however, that central office will be able to review every MSSLC CLDP. Therefore, a system to review a sample of MSSLC's CLDPs is recommended. Further, it may be possible for the MSSLC transition specialists and the QA department to review a sample of CLDPs, too. To do so, some sort of tool will need needed, one that is better than the current tool being used to self-monitor CLDPs (see T1g).	
	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. To maintain substantial compliance, every CLDP ENE support needs to also include a date of required implementation, not only that it would be monitored during the 7-, 45-,	Substantial Compliance

		and/or 90-day post move monitoring intervals. A specific date was not included in many of the CLDPs.	
	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.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	MSSLC made further improvements in the way it conducted and managed assessments in preparation for each individual's CLDP meeting and transition and, thereby, MSSLC maintained substantial compliance with this provision item. The systems described in the previous report continued and their description is not repeated here. The further improvements were, in response to recommendations in the last report, as follows. First, the tracking sheet used by the APC now included specific dates rather than checkmarks. Second, in the body of the CLDP, the APC added in a third component to the description of IDT's review of each of the assessments. Thus, one described the deliberations (i.e., discussion) of the IDT regarding the assessment, a second listed the recommendations taken verbatim from the written assessments, and the new third component, listed the recommendations resulted from the deliberations. Third, the APC conducted a brief training session with some of the discipline department heads regarding the CLDP requirement for 45-day discharge assessments and updates.	Substantial Compliance
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-	MSSLC continued to make incremental progress in this provision item since the last onsite review. Overall, much progress was made since the baseline review in March 2010. This was good to see and will likely eventually result in substantial compliance with this provision item. The ENE support list is one of the most important, and probably the most complicated, part of the CLDP. Positive aspects in the identification of an adequate list of essential and nonessential (ENE) supports continued, such as: • Individuals had approximately 4 essential supports and more than 20 nonessential supports, that is, a total of between 25 and 30 ENE supports. • There was continued progress in the inclusion of individualized ENE supports. • There were some standard ENE supports in almost every CLDP, such as taking	Noncompliance

	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.	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 continued to be acceptable and reasonable. • ENE supports continued to include some detail on what information needed to be brought to the new PCP. Some general comments are below. The APC and her staff should attend to these as they move forward with continued improvement of the CLDP list of ENE supports. • Implementation of every important <u>aspect</u> of MSSLC plans (e.g., PBSP, PNMP, dining plans) needs to be included in the list of ENE supports (i.e., not only a general statement that the PBSP and PNMP will be implemented). • The most prominent example was the failure to ensure that the provider implemented all of the important aspects of the recommended PBSP. Although many CLDPs called for implementation of the PBSP and required documentation of the occurrence of problem behaviors, maintained behaviors, and replacement behaviors (this was good to see and an improvement since the last review), the CLDPs did not require the implementation of important individual-specific components of their successful PBSPs. For example, o Individual #181's PBSP (and CLDP) clearly noted that praise and attention were very important. In fact, his CLDP (and other individuals' CLDPs, e.g., Individual #249) included the statement "He cannot be over praised…" in bold letters. Further, Individual #181's PBSP stated that he needed to be kept busy, engage in problem solving conversations once per shift, and do a self-management activity each evening in which he planned for the next day. These important aspects of his PBSP were worthy of their own ENE support. o The PBSP for Individual #572 noted to watch for signs of his problem behaviors, such as him getting agitated, but were not noted as an ENE support. o Strings and paper clips needed to be made available to Individual #32 at all times, but not noted as an ENE support. o Individual #379 needed to be provided a lot of attention and praise, be notified about changes, and be monitored near children. These were not in his ENE support list. o Individual #461 needed to be kept busy participating in engaging activities. A point system was used successfully. Neither of these supports were in his list of ENE supports. o 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 many of these individuals. • More attention should be paid to the individuals' desires to be employed. This	

		was noted as a very important support need for almost every individual. The ENE supports, however, tended to be about attending day habilitation, being referred to DARS, and completing job applications. The monitoring team understands that finding employment can take a long time, often much longer than the IDT, provider, and individual expects. Further, many individuals do not have a good understanding of what it may mean to be unemployed, or looking for employment, for many many months. Therefore, this should be explicitly addressed in each CLDP and in the list of ENE supports. This was done to varying degrees, in some, but not all, CLDPs. • Individuals had numerous skill acquisition plans at MSSLC, but these were, for the most part, not carried forward. For example, skill acquisition programming was not included as an ENE support even though it was recommended for Individual #572 and Individual #379 for skills, such as vocational and money management. o On the other hand, there were some examples of skills training ENE supports. Specifically, there was an ENE support for skills training on making good food choices for Individual #461s, and skills training on making good food choices was recommended for Individual #461s, and meal planning for Individual #199. • Almost always, important preferred activities, items, foods, social activities, etc. were combined into a single ENE support. These should be separated in to more than one ENE, perhaps by topic area or by activities that occur in the home versus activities that occur in the community. Further, some had a very low criterion, such as occurring only once or twice per month. A more reasonable criterion should be considered. • Evidence of the assessment of competency should be, but was usually not, included whenever training was listed as an ENE support. • The monitoring team's review of the CLDPs and accompanying documents indicated that some important supports might have been overlooked. Some of these are listed below. Note, however, that even though more work was needed, MSSLC continued to make progress in this area. o Individual #548 had a history of extensive serious behavior and psychiatric problems, including predatory behaviors with women and diagnoses of antisocial personality disorder and intermittent explosive disorder. The CLDP noted that there had been no occurrences in more than 15 years, but that he had been living in a highly supervised environment (the SSLC) that whole time. There was nothing in the CLDP about how supervision would be ensured and/or the results of any type of risk assessment. o Individual #249's CLDP seemed to missing ENE supports related to weight loss/dieting and volunteer work. The CLDP also had notes about there needing to always be two staff present on the home and him not	

		being alone with female staff. These aspects of his support were not directly addressed with ENE supports. o Individual #379 had support needs regarding attending and participating in group and other therapies, and following his diet and exercise regimens, that were not on his list of ENE supports. o For Individual #199, ENE supports for bicycle riding and self-administration of medication seemed to be areas for which an ENE support might have been appropriate. o Individual #75's CLDP indicated that he had a desire for driver education, but it did not appear in the list of his ENE supports. The monitoring team suggests the APC (or transition specialist or PMM) do an ENE support self-assessment prior to finalization of the list of ENE supports. A suggested initial list of items for a self-assessment of ENE supports is bulleted below. • Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. • All safety, medical, and supervision needs were addressed. • What was important to the individual was captured in the list of ENE supports. • The list of supports thoroughly addressed the individual's need/desire for employment. Many individuals are excited to move to the community and do not fully understand that it may take months, if not longer, to find a job. • Positive reinforcement, incentives, and/or other motivating components to an individual's success procedures were included in the list of ENE supports. • There were ENE supports for the provider's implementation of supports. That is, 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. • Topics included in training had a corresponding ENE support for implementation. • Any important support identified in the assessments or during the CLDP meetings that was not included in the list of ENE supports should have a rationale. • Every ENE support included a description of what the PMM should look for when doing post move monitoring (i.e., evidence). This provision item also requires that: • Essential supports that are identified are in place on the day of the move. A pre-move site review was conducted for all individuals. Moreover, the admissions and placement staff member who conducted the review continued to bring along an IDT member (usually the QDDP, but sometimes the psychologist, RN, SLP, or master teacher). Each review indicated that each essential support was in place.	

		• Each of the nonessential supports should have an implementation date. This was not the case for all of the ENE supports (also noted in T1d). • Although not required, the IDTs continued to hold a meeting following every pre move site review (100%). This was good to see.	
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 again made only little progress towards implementing a quality assurance process. There was no organized, easily explained QA process as required by this provision item. To try to determine what it was that the department did since the last onsite review, the monitoring team again looked at the materials submitted. These were the APC's quarterly section review of progress materials presented to PET and QAQI Council in July 2012, bar graphs that summarized the scores on the self-monitoring tools, printouts of the actual scores on a number of self-monitoring tools, three packets of graphs that the monitoring team had to re-assemble because there were multiple copies of some graphs and some graphs had the same titles but different bar graphs (the graphs were for some of the types of data listed in T1a), and the department's self-assessment, action plans, and actions completed. First, for the next onsite review, the APC should organize her presentation of data, graphs, PET/QAQI Council, and Admissions and Placement QA activities so that it can all be easily understood by the monitoring team. Second, the quality assurance process for section T needs to be planned out and included in the facility-specific policy for most integrated setting practices. The monitoring team recommends that this be a separate facility-specific policy. When planning a full quality assurance process for section T, all aspects must be included (e.g., living option discussion, CLDP development, CLDP content, ENE supports, CLDP implementation, post move monitoring). The APC, and other staff in the department, appeared to use the statewide self-monitoring tools regularly. The monitoring team's comments regarding these tools from previous monitoring reports in sections T1f and E remain applicable and should be reviewed by the APC.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of	The same state and facility report that was discussed in the previous monitoring report was again submitted. It was an annual report. The new report was due sometime in October 2012. Because this was the same report, please refer to the previous monitoring report for discussion. In addition, the APC submitted two lists, both labeled community placement options. One had data for 164 individuals. It was dated 9/1/11 through 7/24/12 (almost one full year) and the name of each individual was attached. The other was dated 3/1/12 through 9/6/12, but did not have any names attached. It was unclear to the monitoring	Noncompliance

	obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	team as to how these data were used, whether these were obstacles to placement or obstacles to referral, and if the IDT was able to list more than one obstacle (the monitoring team believes the database only allowed for the entry of one item).	
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	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 3/1/12 through 9/27/12. 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

	transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	MSSLC maintained substantial compliance with this provision item. Timeliness of Visits: Since the last review, 55 post move monitorings for 27 individuals were completed. This compared to 38 post move monitorings for 16 individuals at the time of the last review. Post move monitoring occurred all over the state. This was 100% of the post move monitoring that was required to be completed. All 55 (100%) occurred within the required timelines. The TS or PMM visited both the residential and the day program sites. The PMM maintained a spreadsheet that listed all of the individuals, the due date for each post move monitoring, and the date upon which the post move monitoring occurred. This was a useful tool. The monitoring team reviewed completed documentation for 47 of these 55 (85%) for 21 of the 27 individuals (78%). Of these 47 monitorings, 22 were competed by Transition Specialist (TS) Dana Cotton, 19 by Transition Specialist Pamela Gonner, and 6 by Post Move Monitor (PMM) Sarah Ham. Content of Review Tool: All 47 (100%) post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. For the most part, the post move monitoring report forms were completed correctly and thoroughly. Good information was included. The monitoring team greatly appreciated the organized presentation of the post move monitoring documents. Clearly, the TSs and PMM put a lot of effort and thought into	Substantial Compliance

		ensuring that the materials were complete, organized the same way for every individual, and clearly labeled. Below are comments regarding the content of this set of 47 post move monitorings. • Overall, the reports indicated that the TSs and PMM were conducting post move monitoring as per the requirements and intentions of this provision item. o The monitoring team liked that the staff completed the checklists in a cumulative format. This made it very easy for the reader to follow the individual through his or her first 90 days in the community. • Surprisingly, there was no action taken in response to the monitoring team's comments and recommendations in the previous report. In other words, the staff who were completing excellent reports continued to complete excellent reports and the staff who completed acceptable reports that needed some improvement, continued to complete reports in the same way. The monitoring team found Pamela Gonner's reports to be particularly detailed, informative, and descriptive of her post move monitoring actions as well as the individual's experience in his or her new home (e.g., Individual #167, 45-day review, page 5). Below are topics that the APC needs to address in order to maintain substantial compliance. Many are carried over from the previous monitoring report. o The comment "There are no concerns or recommendations" was frequently the only information provided in most of the sections of many reports. This comment was, by itself, insufficient, especially given the amount of time the TSs and PMM put into doing these visits and reports. By only making this comment, the reader was unable to get a good understanding of how the individual was doing in his or her new placement. o Some reports included good information as to what the TS or PMM did under the "Evidence reviewed" column. This should become standard practice for all reports. o Some ENE supports were scored No because the action was completed during a previous post move monitoring. This was confusing to the reader because the No score made it appear that the provider was not providing that support. Instead, the TSs and PMM need to make it clear to the reader the status of each ENE support. o Within the series of additional questions, some reports had the individual's psychiatric diagnoses, psychiatric medications, and medical conditions inserted right into the post move monitoring form. This should be standard practice. o Not all reports indicated the name and position of the staff who were interviewed and/or adequately described the results of the interviews. o The TSs and PMM need to ensure that staff training was done adequately. Some post move monitoring forms only noted that	

		inservice sheets indicated training was done and that the staff was competent based on training provided. The TS or PMM should provide more information about what she did to determine that the provider adequately trained staff and assessed their competency. o LAR/family satisfaction with the placement (question #9) and the individual's satisfaction (question #11) should be explicitly stated in the comments section in every review. o 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). The TSs and PMM should ensure these get included in the CLDP when it is developed. ▪ For example, Individual #564's post move monitoring form had two pages of detail regarding many aspects of his BSP. The TS, however, only noted that she reviewed the attached data collection form. Of the 21 individuals who received post move monitoring that was reviewed by the monitoring team, 20 (95%) transitioned very well and appeared to be having great lives. One appeared to be going through some transition problems that were, perhaps, not being adequately addressed by his provider (Individual #354). The high percentage of individuals who had a good transition and who were having good lives in the community demonstrated ongoing efforts by the admissions and placement staff and by the IDTs to continually improve the referral and placement process at MSSLC. As discussed with the APC, a simple review should be done of all placements to find out if any serious incidents occurred for the period of one year following placement. A simple phone call would be an easy way to obtain this information. This information would add to the admission and placement staff's knowledge about somewhat longer term outcomes for individuals and help them in their desire to have a program of continual improvement in the way they manage placements and post move monitoring. Use of Best Efforts to Ensure Supports Are Implemented: IDTs, the APC, and the TSs and PMM put a lot of effort into these placements. The TSs and PMM appeared to do a good job of following up when there were problems, however, the monitoring team requests that more detail be provided in future post move monitoring reports, so that the reader can fully understand the efforts made by the TS or PMM. Examples where follow-up was clearly described were staff needing additional inservices (Individual #249, Individual #254) and missing adaptive equipment (Individual #32). Examples where follow-up should have been described in more detail were for clinician	

		and physician appointments that were not made by the required date (Individual #453) and problems with the provider's ability to fix holes in bedroom walls and get the individual's walker to his day program (Individual #354). Further, it appeared that all issues for Individual #75 were not resolved at the 90-day review. In cases such as this, the TS or PMM can, and should, extend post move monitoring. To maintain substantial compliance with this aspect of this provision item, the monitoring team will expect to see sufficient detail in the post move monitoring reports to demonstrate that adequate follow-up occurred. IDT meetings were held following the post move monitoring visits. This was good to see. Documentation of these meetings was submitted for 47 of the 47 (100%) post move monitorings reviewed by the monitoring team.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The monitoring team accompanied the PMM Sarah Ham on a 7-day post move monitoring visit to the home of Individual #32. The individual had moved to his new home only a few days prior to this visit. He lived in a very nice home operated by A-Trinity. He lived with three other men in a home that became a group home about two months ago. Individual #32 had his own bedroom. He sat in the living room on the couch during the post move monitoring visit. The PMM conducted the post move monitoring in a very professional manner, proceeding through all of the items, asking questions, and asking for documentation. As a result, MSSLC maintained substantial compliance with this provision item. The home manager, Darren Bolton, and the home staff member, Janeesha Houser, were very knowledgeable about Individual #32. They described his favorite activities, driving in the van, and so forth. The owner of A-Trinity, Allen Gould, was also present. He was very responsive to requests and questions from the PMM. Overall, the monitoring team was very impressed with the services being provided to Individual #32 and with the provider agency, its owner, and the staff who worked in the home. The PMM interviewed both of the staff, sometimes together, sometimes alone. She asked about the individual's psychiatric condition, behavioral problems, medical concerns, abuse and neglect reporting requirements, adaptive aids, helmet, diet, and medication administration and storage. The staff correctly responded to these questions. The PMM did not provide leading questions, though she did engage in a pleasant back and forth conversation that appeared to make the staff as comfortable as they could be, given the presence of the monitoring team, APC, and A-Trinity owner. She went through the list of every ENE support. The monitoring team discussed various	Substantial Compliance

		aspects of the ENE supports for which a staff checklist could have been created to provide additional documentation of the provision of the ENE support. The monitoring team reviewed the completed post move monitoring report, which was submitted during the week following the onsite review. The content corresponded with what the monitoring team observed. The monitoring team had observed Sarah Ham during the previous onsite review, too. The monitoring team requests that one of the other TSs be observed during the next onsite review, especially given that Ms. Ham conducts only about 10 percent of the post move monitoring.	
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	There were 17 individuals reported as being discharged per the criterion of section T4. Of these 17, 8 were no longer eligible for services and/or had their charges dismissed, 8 were transferred to another SSLC, and 1 was discharged to a medical facility. The discharge reports were improved from the time of the last review, however, the important last section of the report, regarding referrals and/or necessary services required in new environment was not adequate in almost every report. This is a very important section because, in it, the APC needs to describe what is needed in the next setting. This section also should highlight the most important needs of the individual. For some individuals, this section was blank or missing. For others, it did not contain any useful information. For others, it contained information from some, but not all, relevant	Noncompliance

	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.	areas of the individual's life. Eight of the 17 were transfers to other SSLCs. This is likely to continue because MSSLC was moving towards being a forensic facility and individuals (and their LARs) were given the opportunity to request a transfer. If so, the APC needs to ensure that the receiving SSLC receives adequate and thorough information. A few months after the transition, the APC might ask the receiving facility if adequate information was received. This information could then be shared with the monitoring team during future onsite reviews.	

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 (e.g., Placement Appeal) (T1a).

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

3. Do a detailed review (i.e., root cause analysis) of each rescinded referral and any other untoward post move serious incidents to determine if anything different should be done in future transition planning to reduce the likelihood of these types of problems occurring. In particular, do a review of the deaths that have occurred after transition to the community (T1a, T2a).

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 bullets in T1a should be graphed separately, and included as part of the facility's QA program (T1a, T1f).

6. Implement procedures so that professionals' opinions and determinations regarding community placement are in their annual assessments, in the ISP meeting discussion, and in the ISP document (T1a, T1b3).

7. The monitoring team has noted at least three different "approaches" to way professionals give their determinations and opinions. All three should be included. Provide more direction to the professionals, so that there is a consistent approach to this requirement (T1a, T1b3).

8. Do an oral presentation to senior management of referral status of those who have been referred, and the post move lifestyle status of individuals who have moved (T1a).

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

10. Upon referral, the APC should seek out the IDT and others as noted in T1b1 to talk about what training objectives might be considered now that the individual was referred for placement (T1b1).

11. Address obstacles to referral and placement at the individual level (T1b1).

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

13. Ensure that there are thorough living options discussions and living option determinations. The living option determinations should include a clearly worded rationale for the decision made by the IDT as a whole (T1b3).

14. Address gaps in placement activity. At a minimum, describe why gaps occurred (T1c).

15. Include date of initiation of CLDP on the cover page of the CLDP (T1c).

16. Prepare the individual and his or her direct support staff for actively participating in the CLDP meeting (T1c).

17. Provide more information on the training of provider staff (e.g., to whom, method, demonstration of competency) (T1c1).

18. Collaborate with community and provider clinicians, especially but not limited to the PBSPs (T1c1).

19. Document the completion of the day of move activities (T1c1).

20. Consider developing a self-assessment of the CLDPs (T1c1).

21. A full comprehensive set of ENE supports must be chosen for each CLDP. As noted in T1e, ensure that proper attention is paid to employment, skill acquisition planning, and preferred activities and items (T1e).

22. Ensure that all topics included in training have a corresponding ENE support for implementation (T1e).

23. Clearly describe the ways the PMM should evidence the occurrence of the <u>implementation</u> of supports by the provider (T1e).

24. The monitoring team suggests the APC do an ENE support self-assessment prior to finalization of the list of ENE supports. A suggested initial list of items for a self-assessment of ENE supports is bulleted in T1e (T1e).

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

26. Develop new self-monitoring tools (T1f).

27. The APC needs to address the open bullets listed in T2a in order to maintain substantial compliance (T2a).

28. More detail regarding follow-up actions taken by the transition specialists and PMM must be provided in future post move monitoring reports so that the reader can fully understand the efforts made by the TS or PMM (T2a).

29. Extend post move monitoring beyond 90 days if all issues are not resolved at the 90-day review (T2a).

30. T4 discharge reports need to be completed thoroughly and completely, especially the final section, regarding recommendations (T4).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o MSSLC Guardianship Policy dated 6/21/12 o Decision Making/Functional Capacity Assessments for : • Individual #151, Individual #568, Individual #224, Individual #29, Individual #297, Individual #389, and Individual #209. o MSSLC Section U Presentation Book o A Sample of HRC Minutes o MSSLC Prioritized Guardianship/Advocate List o A list of individuals for whom guardianship had been obtained in the past six months. o Documentation of activities the facility had taken to obtain LARs or advocates for individuals Interviews and Meetings Held: 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 Alynn Mitchell, Acting QDDP Coordinator o Joy Lovelace, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 9/24/12 and 9/26/12 o ISP preparation meeting for Individual #94 o Annual IDT Meeting for Individual #151 o Quarterly QA/QI Meeting
	Facility Self-Assessment: MSSLC submitted its self-assessment. The self-assessment was updated on 9/6/12. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment, the results of these self-assessment activities, and a self-rating for each item. The facility self-assessment described criteria used to evaluate compliance for each item and details on specific findings. For example, for item U1, the self-assessment activities engaged in by the facility included a review of three ISPs each month between April 2012 and August 2012 and a review of all Rights Assessments updated during the same time period. The result of the self-assessment was described in detail. Comments were similar to the monitoring teams comments for each provision item.

	The facility self-rated U1 and U2 as not in compliance. The monitoring team agreed with the facility's compliance rating for U1 and U2. The newly developed audit tool should be beneficial in guiding the facility's efforts to achieve compliance with section U.
	Summary of Monitor's Assessment: Some positive steps that the facility had continued in regards to consent and guardianship issues included: • QDDPs had received training on the new guardianship policy. • Letters had been mailed to correspondents and family members concerning how to obtain guardianship. • The Human Rights Officer had revised the rights assessment to include prompts that might lead to discussion on whether or not the individual had the ability to give informed consent in a number of areas. These actions were good steps towards ensuring that the priority list for guardianship is accurate, which is compliance with U1. Then U2 will be the next step which is procuring guardians for individuals assessed as high priority. Although positive changes had been made to the assessment of functional decision-making capacity, given the complexity of such an assessment, the facility should coordinate its efforts with state office. The state is encouraged to finalize the consent policy, because it should assist the Facilities in moving forward with regard to the implementation of the section U Settlement Agreement requirements. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The monitoring team commends the facility's progress in attempting to identify individuals that are in need of an LAR through IDT assessment and discussion. In order to gain compliance with U1, the facility will need to ensure that all IDTs are 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. Once a priority list of those in need of a guardian has been developed, then the facility can move forward with procuring guardianship for individuals with a prioritized need.

#	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 continued to make progress on obtaining compliance with the requirements of section U under the direction of the newly appointed Human Rights Officer. A prioritized list of individual lacking both functional capacity to render a decision and a LAR to render such a decision had not yet been created. The following steps had been taken by the facility to work towards compliance: • QDDPs had received training to identify those individuals in need of an LAR. • The facility's rights assessment had been revised to include prompts that would guide the IDT in determining whether or not a guardian or advocate was needed for each individual. • The facility continued to provide information to family members regarding the guardianship process. • Reminders to renew guardianship were mailed out to families prior to guardianship expiration dates. A sample of functional capacity assessments was reviewed including the assessments for Individual #151, Individual #568, Individual #224, Individual #29, Individual #297, Individual #389, and Individual #209. The assessments did not document meaningful discussion among the IDT to support the approved restrictions or include measurable goals for removing the restriction. For example, • The assessment for Individual #309 noted that the team agreed 1:1 supervision was appropriate for his protection due to inappropriate sexual behavior, aggression towards others, unauthorized departures, and stealing. The plan to remove the restriction was "when he becomes more psychiatrically stable." Criteria was not established for determining when that would occur. IDTs were not yet holding 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. In the annual IDT meeting observed for Individual #151, the IDT acknowledged his need for guardianship and reported that his sister had been mailed information about guardianship. She was not present at this meeting and had not pursued guardianship in the past. The team agreed that moving him to another state supported living center was appropriate regardless of proximity to his sister even though his sister had expressed a desire for him to live closer to her. The team discussed many important issues that should have included input from an advocate or guardian since he was unable to comprehend the decisions being made about his life.	Noncompliance

#	Provision	Assessment of Status	Compliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. Two individuals had been assigned new guardians since the last visit by the monitoring team. A prioritized list of individuals that need guardians or advocates will need to be developed to proceed with U2. The facility did have some rights protections in place, including an independent assistant ombudsman housed at the facility, and a human rights officer employed by the facility. The facility continued to offer self-advocacy opportunities for individuals at the facility, including an active self-advocacy group. There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at MSSLC. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process.	Noncompliance

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 based on IDT recommendations (U1).
3. Explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals (U2).

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o MSSLC recordkeeping-related policies: • Recordkeeping practices Adm#6, revised 8/21/12 • Individual notebook procedure Adm#7 12/5/11 • Monitoring of individual notebooks Adm#8 12/15/11 • Documenting in the observation notes, revised 4/19/12 • Master record, Adm#12, DRAFT o Emails regarding edits on some of these policies, 5/30/12 o MSSLC organizational chart, 9/1/12 o MSSLC policy lists, August 2012 o List of typical meetings that occurred at MSSLC, undated, likely August 2012 o MSSLC Self-Assessment, 9/6/12 o MSSLC Action Plans, 9/6/12 o MSSLC Provision Action Information, most recent entries 8/7/12 o MSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/24/12 o List of all staff responsible for management of unified records o Tables of contents for the active record updated 7/11/12, individual notebooks 5/19/11, and the master records 4/9/12 o List of other binders or books used by staff to record data (eight), and a series of emails regarding gathering this information, 8/7/12 o Description of the MSSLC shared drive o Staff training materials regarding documenting in the active record, including emails and sign in sheets (Acknowledgement of Responsibility Active Records), August 2012 o Emails regarding consents and observation notes, June 2012, August 2012 o PET report for section V, May 2012 – August 2012 o Nutrition department recordkeeping proposal 5/24/12 and update note 9/27/12 o A one-page spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, undated, probably August 2012 o MSSLC policy cross reference tracking tool, 9/19/12 o Data regarding training on state and facility-specific policies (none) o Email regarding state office expectations for facility-specific policies, from central office SSLC assistant commissioner, Chris Adams, 2/15/12 o MSSLC emails regarding section V2, 5/23/12 o Medical consultation tracking and scheduling documents o Blank tools used by the URC

	o List of individuals whose unified record was audited by the URC, March 2012 through August 2012 o Completed unified record audit tools for 10 individuals, July 2012 and August 2012 • Statewide self-monitoring tool • Active record and individual notebook • Master record • V4 questionnaire (none) • Comments o Summary of corrections needed, March 2012 through August 2012 o Audit tracker, March 2012 through July 2012 o Email noting corrections needed for June 2012 audit, 7/2/12 o Delinquent documentation tracking form, blank, used by record clerks, with data graphs from 4/20/12 through 7/13/12 o One paragraph description of how MSSLC addresses section V4, and a one page V4 tool, undated o Review of active records and/or individual notebooks of: • Individual #382, Individual #137, Individual #241, Individual #142, Individual #164, Individual #104, Individual #202, Individual #66, Individual #216, Individual #575, Individual #177 o Review of master records of: • Individual #525, Individual #420, Individual #252, Individual #861 <u>Interviews and Meetings Held</u>: o Elaine Schulte, Director of Client Records o Sherrie Price and Misty Samuels, Unified Records Coordinators o Home record clerks and recordkeeping staff, 9/27/12 o Various staff, including Debbie Reichert, recordkeeping; Lisa Newsome, master teacher; Alison Cotton, DSP; Lila Brewer, DSP; Tracy George, nursing. <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area o PET IV, CLDP, and ISP meetings
	Facility Self-Assessment MSSLC continued to use the self-assessment format it developed for the last review. The Director of Client Records (DCR) and the Unified Records Coordinators (URC) had further developed what they presented last time by including additional activities and outcomes. In that regard, they made progress in that they were trying to look at actual activities and outcomes for each provision item. The most important next step is for the DCR and URCs is to make sure that they include everything in the self-assessment that the monitoring team looks at. This can be done by going through the monitoring

	team's report, paragraph by paragraph, and including all of those topics in the self-assessment (and perhaps in a new self-assessment tool, too). It is possible that new tools might include everything that comprises the self-assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. For example, in V1, they correctly self-assessed whether every individual had a unified record that contained all three components, and they reported on the results of their use of the statewide self-monitoring tool. These were appropriate activities to include in a self-assessment for V1, however, the monitoring team also looked at (i.e., assessed) a number of other aspects in V1, including the status of policies, and the results of the table of contents reviews. For V2, there was also progress in self-assessment in that the activities included a review of their own spreadsheet and a review of staff training. These were the primary outcomes that the monitoring team also looked at. For V3, the DCR and URCs correctly self-assessed by reviewing whether some important aspects of the quality assurance monthly audit process were being done adequately, such as looking at record audits and graphs. Then, however, they went on to describe the results of these activities rather than self-assessing the quality of the audit process, the number of audits, the error/correction data, graphs, action plans, and so forth. The outcome of the audits is a self- assessment of the unified record and, therefore, is a part of the self-assessment of V1, not part of the self-assessment for V3. For V4, they reported on the only two activities that were being conducted (V4 interviews and IPN reviews). As noted in V4 below, there are six aspects to V4 that need to be implemented and self-assessed. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the DCR and URC and believes that the facility was continuing to proceed in the right direction. The facility self-rated itself as being in noncompliance with all four provision items of section V. The monitoring team agreed with these self-ratings.
	Summary of Monitor's Assessment: MSSLC demonstrated continued progress. Staff addressed most of the comments and recommendations in the previous monitoring report. The active records continued to be in good shape. Improvements noted in the previous report were continued. A variety of staff described their use of the individual notebooks and active records. Even so, there continued to be a need for further improvement in the active records as found in the facility's own reviews and in the monitoring team's review of a sample of active records and individual notebooks. The main areas for improvement were documents missing from the active record (primarily ISP-related assessments and forms) and improving legibility of written entries. Documents were often

	taken out of the active record, often to be photocopied, but were either replaced in the wrong place in the active record, or not replaced at all. Active records were often missing, though fortunately never permanently. The master records were all updated to the new table of contents. They were in good form, consistent from record to record, and easy to use. MSSLC improved upon its one-page spreadsheet listing out all 20 provisions of the Settlement Agreement and the corresponding state and facility-specific policies. Details from the assistant commissioner's 2/15/12 email were incorporated into this spreadsheet. Not all state policies were in place yet, though continued progress was evident. A system for conducting and managing training of these policies was needed. Five quality reviews (audits) were conducted in each of the previous six months. One unified record was chosen from each of the five units each month. The reviews were done in a fairly consistent manner and were neatly and clearly documented. The typical number of corrections needed was around 11 to 12 per unified record. Eight other binders/logs where individual data were recorded will need to be incorporated into the audit system. The URCs had re-initiated some graphing of their data. The monitoring team discussed this at length during the onsite review and made recommendations for a specific set of graphs to be created. The same procedures were implemented for provision item V4, that is, short interviews of staff following ISP meetings and a review of IPNs. No action was taken to explicitly address the six aspects of V4 that were reviewed during the last monitoring review (and reviewed again during this onsite review).

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	MSSLC demonstrated continued progress with the unified record as required by this provision. Recordkeeping remained under the supervision of Elaine Schulte, Director of Client Records (DCR), however, the facility leader for this provision was now Sherrie Price, one of the Unified Records Coordinators (URC). She worked along with Misty Samuels, the other URC. All three worked well together. They addressed most of the comments and recommendations in the previous monitoring report. This included fixing some of the aspects of recordkeeping that had regressed since the review of one year ago, responding to recommendations in the report of six months ago, and implementing some new procedures. All of this is described in the report below. In addition, the recordkeeping staff did a very nice job of preparing the presentation book. Doing so made it easy for the monitoring team to understand their activities and how these activities related to their own action steps and to some of the specific recommendations in the previous monitoring report.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Since the last onsite review, the DCR had obtained a new record room in each of the Whiterock homes. The new record rooms in homes visited by the monitoring team were clean, newly painted, locked, and with tabletop space for staff to use. The DCR was pleased to report this to the monitoring team and the monitoring team was pleased to see it. A short annual refresher staff training session was developed by the URCs. It included a handful of slides with appropriate content. This was good to see. The facility reported that many staff had received this training to date. The provision action information list noted a start date of 7/2/12. The monitoring team had the opportunity to meet with the record clerks. About half of the clerks were new since the last review. Overall, they were a quiet group, however, based on the reports of the DCR/URCs and the monitoring team's review of the unified records, they appeared to be doing a thorough job. Some of their comments are noted in the report below. State policy remained the same since the last review. Facility policies were improved in that the DCR addressed the comments in the previous report by making edits to policies Adm#6 and Adm#8. Further, she drafted a new policy on master records, Adm#12. The table of contents and maintenance guidelines were updated in July 2012 for the active record, May 2011 for the individual notebooks, and April 2012 for the master records. The master record table of contents update was based on suggestions from state office. Two activities were discontinued since the last onsite review and/or their use was severely decreased. These were the AAUD data on individual notebooks and the Active treatment monitoring and coaching tool. The monitoring team does not have an opinion or recommendation regarding these two tools, but thought it important to note this change in this report. <u>Active records</u> The active records continued to be in good shape, due in large part, to the work of the record clerks. The monitoring team reviewed active records in each of the five units at the facility. Improvements noted in the previous report were continued (but are not detailed again here).	

#	Provision	Assessment of Status	Compliance
		Improvements included: • A few minor edits were made to the active record table of contents. These seemed to make sense, such as moving the psychoactive medication consent to the PBSP section. By leaving the notation on the table of contents, however, the reader could easily see the change. • The specification of what consents should be in the active record was addressed. • The issue regarding the absence of social histories was also addressed. The monitoring team spoke with the DCR about what to do for those individuals for whom a social history cannot be located. The monitoring team suggested that the active record contain a short paragraph indicating that the DCR spoke with the IDT (or the QDDP). If the IDT stated that its absence did not hinder their clinical work, the DCR could make a note to that effect in the active record. Then any record audits (see V3) would rate this item as N/A rather than as a No. • The above two issues, regarding consents and social histories, were also addressed in the new draft policy Adm#12. • Regarding IPNs: o The dental department was no longer incorrectly placing documents into the IPNs. o IPN content was addressed in the revised Adm#6 policy. State direction on what should and should not be in the IPN was still expected from state office. o A question remained as to where quarterly medical reviews should be placed. The medical department wanted these reviews placed directly in the IPNs. The monitoring team found that the placement of the QMS in the IPN did not impede the flow and readability of the IPNs. Further, the IPNs remained in the active record for a rolling 12-month period. The monitoring team, therefore, does not have an opinion or recommendation regarding the placement of the QMS. If a clinician wanted to find a QMS from previous quarters, however, it might be difficult to easily locate it within the IPNs. o There was collaborative work between the recordkeeping department and the facility's nutritionists to improve their documentation in the IPNs. • The blank observation note was reviewed and mercifully reduced from 9 pages to two two-sided pages. Lisa Newsome, a master teacher, showed the monitoring team those parts of the active record for which she was involved and/or responsible. This included the FSA and the SAPs/SPOs. She appeared very knowledgeable and fluent with the active record, showing the monitoring team how she used the FSA and where in the FSA she had	

#	Provision	Assessment of Status	Compliance
		written her summary of the FSA (i.e., the life skills summary section). She said that she integrated this information with the PBSP. She also pointed to the data sheet completed by instructors and said that the master teachers oversaw the instruction and data collection, and that they conducted the reviews of each SAP/SPO. Further, Tracy George, RN, told the monitoring team that the active records were set up in a way that made it easy to find what she needed. Even so, there continued to be a need for further improvement in the active records as found in the facility's own reviews (URC V3 audits and record clerk audits) and the monitoring team's review of a sample of active records and individual notebooks (e.g., Individual #137 missing consents, recent ISP). The main areas for improvement were documents missing from the active record (primarily ISP-related assessments and forms) and improving legibility of written entries. One of the ways the facility tried to ensure that documents were submitted and filed in a timely manner was the creation of the delinquent document tracking log and the re-initiated graphing of these data. Delinquent documentation (D-list) was data from clerks, regarding all progress notes and reports. The DCR and URCs reported that these data varied from month to month, unit to unit, and discipline to discipline. The monitoring team reviewed these data. First, the total delinquent number should be graphed each month so that overall progress can be trended and seen. Second, the set of graphs showing each discipline's percentage of missing documentation was misleading and described incorrectly to the monitoring team. The graphs were described as showing the percentage of documentation that was missing. Thus, "QDDP-60%" was described to mean that 60 percent of the documents that were to be submitted by the QDDPs were missing (i.e., 40% was submitted). This turned out to be wrong. Instead, "QDDP-60%" meant that of all of the documents that were missing across the entire facility, 60 percent were the QDDPs'. To summarize, the URCs should instead create two graphs for the D-list data: • Total number of missing documents per month across the entire facility. • Percentage of each discipline's documents that should have been submitted, but weren't. Further review by the monitoring team during the onsite review indicated two other broad problems with the management of the active records. • Documents were often taken out of the active record, often to be photocopied, but were either replaced in the wrong place in the active record, or not replaced at all. Many staff were doing so, but even if misfiling or removal occurred only a small percentage of the time, it was enough to disrupt the stability of the active	

#	Provision	Assessment of Status	Compliance
		records. • Records were often missing, though fortunately never permanently. Staff often neglected to sign out a record and active record volumes often did not readily return from dental appointments in a timely manner. To combat this problem, some record rooms had a green 8x11 taped to the active records table pleading for use of the sign out book and prompt return of records. One record room (Shamrock 1) had a Check out Card binder regarding taking and returning active records. <u>Individual notebooks</u> MSSLC continued to use individual notebooks. Staff appeared comfortable and knowledgeable about the individual notebooks. For example, Alison Cotton, DSP in Martin, reported that the individual notebooks were easy to use; Lila Brewer, DSP in Longhorn, reported that the individual notebooks were narrowed down and simpler to use than were previous versions; and Fred Arnold, DSP in Whiterock, walked the monitoring team through an individual notebook. He appeared comfortable with, and knowledgeable of, the individual notebook. There were reports, however, that the individual notebooks often were messy and needed to be straightened up. As also noted in section K, data in the individual notebooks were recorded up to date for most individuals observed by the monitoring team. This was an improvement from the last onsite review. The monitoring team noted documents included in two of the individual notebooks that were not in all of the individual notebooks. The monitoring team suggests that the facility consider whether or not to include these in all individual notebooks (they were not on the individual notebook table of contents). One was called Medical directions to staff. It was in the individual notebook for Individual #177. The other was called Signature of review of individual notebook. It was in the individual notebook for Individual #216. Observation notes appeared appropriate and were moved from the individual notebook into the active record in a timely manner. This was done daily, during the overnight shift, by overnight staff. Other binders/logs: The facility reported that most individual data recording sheets were kept in the individual notebook, but there were eight other places where individual data were kept (e.g., bowel movement log, weight log, tooth brushing log). It is fine to keep these other data collection logs and binders, however, they need to be included in the facility's review and audit procedures, too. One way to do so is to add these to the audit of the individual notebooks (because these are daily recordings of individuals' data, as	

#	Provision	Assessment of Status	Compliance
		are the data sheets in the individual notebooks). In addition, the allowance for these additional binders/logs should be incorporated into one of the existing recordkeeping policies (i.e., rather than creating an additional policy). <u>Master records</u> The master records continued to be managed by the DCR and by Misty Samuels, one of the URCs. Ms. Samuels had taken on the task of updating every one of the master records to the new format. Her work was with good outcome, that is, the master records were in good form, consistent from record to record, and easy to use. The colored dividers were clearly labeled. Draft policy Adm#12 somewhat addressed what to do if specific master record documents could not be located or obtained. The DCR now needs to develop a procedure for adding a note, or a page with notes, in the master record indicating what was done to obtain the missing documents and if there was nothing further that could be done. If the notes indicate that a document could not be obtained, future audits of the master record would no longer need to continue to mark those items as missing. <u>Shared drive</u> The shared drive was described to the monitoring team. The recordkeeping department and the quality assurance department reported that there were no items in the shared drive that were not in the unified record as a hard copy. <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 develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	MSSLC improved upon its one-page spreadsheet used to list out all 20 provisions of the Settlement Agreement and the corresponding state and facility-specific policies. Further, details from the assistant commissioner's 2/15/12 email were incorporated into this spreadsheet. Not all state policies were in place yet, though continued progress was evident. The facility also created a second spreadsheet (eight pages) that listed every policy at MSSLC and whether it was related to a Settlement Agreement provision. This spreadsheet, however, only tied (what the facility called) their localized policies to Settlement Agreement provisions. There were many other MSSLC facility-specific policies that were related to Settlement Agreement provisions, such as the ones listed in V1 above for recordkeeping.	Noncompliance

#	Provision	Assessment of Status	Compliance
		For the next onsite review, the facility should specify, for the state and facility policies for each provision of the Settlement Agreement, regarding training: • For each policy, what categories of staff need to be trained. • For each policy, o what type/method of training is needed (e.g., classroom training, review of materials, competency demonstration), o who will be responsible for certifying that staff who need to be trained have successfully completed the training, and o documentation necessary to confirm that training occurred. (Some of this responsibility may be with the Competency Training Department.) • 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). Some trainings occur only once, while others require annual refreshers. • A system to track which staff completed which training. • Data on the number of staff who are supposed to receive training on each and every policy and the number of staff who did receive training on each of these policies. Then, a percentage can be calculated. A table could be created (or this information could be in columns added to the current spreadsheet) that showed every state and facility-related policy. For example, it might be that 100 employees were required to have training on the state and facility restraint policies and 90 were trained at the time of the onsite review. A simple table could show columns for the number of staff required to be trained (e.g., 100), the number who's training was current (e.g., 90), and the resulting percentage (e.g., 90%). Each row of the table could be a state or facility-specific policy.	
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	Progress was demonstrated for this provision item. Some activities that were discontinued at the time of the last review were re-started, new actions were taken some of which were in response to monitoring team recommendations, and audits were done consistently each month. With some additional work, substantial compliance can be achieved in the near future. Five reviews (audits) were conducted in each of the previous six months. One unified record was chosen from each of the five units each month. This was a sensible way to sample from across the facility. With a new division of responsibilities in the recordkeeping department, all audits were done by only one of the URCs. To control for any potential unintentional reviewer drift in rating, an occasional inter-observer agreement should be conducted, either by the other URC, the DCR, or the QA department.	Noncompliance

#	Provision	Assessment of Status	Compliance
	deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	All of the reviews were done in a fairly consistent manner and were neatly and clearly documented. The review consisted of four activities: • Completion of the table of contents review of each of the three pieces of the unified record • Completion of the statewide self-monitoring tool • A listing of all needed corrections • Comments as needed. For the table of contents reviews, the URC found approximately 11 to 12 needed corrections per review, though there was some variability, as would be expected. All items needing correction were counted, even if the same type of error occurred more than once (e.g., missing signature). The master record audit now included three columns (Yes, No, NA) as recommended in the last report. The use of the medical consultation database continued to be used by the URC and was very helpful to her. For the statewide self-monitoring tool, the URC used the information obtained during the table of contents review to make her ratings. Approximately four items were scored as No in each of these reviews. There were some differences across the reviews as to what was scored No, though items 2b and 2c were scored No in almost every one of the reviews. Also, item 4b was scored as No in four of the five audits in August 2012, but not at all in July 2012. Perhaps this was due to a change in criterion or perhaps due to extra attention from the URC beginning in August 2012. After doing these two parts of the review, the URC made a list of all things that need correction in all three parts of unified record and she added comments as needed. Overall, this appeared to be a good system. As noted above in V1, however, the additional binders/logs will need to be incorporated into the monthly quality review audits. The shared computer drive, however, does not need to be part of the quality audits because everything on that drive was to be printed and filed in the active record. The recordkeeping department then notified the relevant facility staff regarding these needed corrections and followed-up on whether the corrections were indeed made. This was an improvement from the last onsite review. Sherrie Price, URC, now had responsibility putting all of the recommendations into an email document for distribution. She also responded to the monitoring team's previous recommendation to identify which facility staff were responsible for which specific corrections. To do so, she used the San Antonio SSLC's system of color-coding each recommendation. This was done on the Summary of Corrections Needed/Problems Identified document each month.	

#	Provision	Assessment of Status	Compliance
		Then, Ms. Price managed whether corrections were completed. This was documented each month on a form called the Audit Tracker. The recordkeeping department followed corrections for two months, as also recommended in the previous monitoring report. The Audit Tracker was a simple listing of each of the required corrections with two columns, one for each of the two subsequent months. Then total number corrected out of the total possible was given at the bottom of each column. This was a reasonable way to present this information. Emails to facility staff requesting follow-up were done in a pleasant and professional tone. The URCs had re-initiated some graphing of their data. The monitoring team discussed this at length during the onsite review. To follow-up to that discussion, and as requested by the URCs and DRC, below is a listing of the types of graphs that should be created: The monitoring team recommends that there be one line graph for each of the following, with one data point per month, with successive consecutive months one after the other so that trends can be easily seen: • Average score on statewide self-assessment tool portion of the audit. • Number of errors regarding legibility, etc. (i.e., continue the current set of six graphs, but make six separate small graphs instead of having all six lines on a single graph). • Total number of corrections/problems found for all five reviews. o Optional: make additional graphs showing the number of corrections/problems per each facility department. • Percentage of items that were corrected within the specified two-month time period. o Optional: make additional graphs showing the percentage of items corrected per each facility department. • Amount of delinquent documentation, taken from the D-list reports made by the record clerks. o Total number of missing documents per month across the entire facility. o Percentage of each discipline's documents that should have been submitted, but weren't. All of these graphs should be included in the QA program's data inventory, QA matrix, QA report, and PET data.	

#	Provision	Assessment of Status	Compliance
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.	During the previous review, and in the previous monitoring report, the monitoring team detailed the activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. The monitoring team, DCR, and URCs discussed V4 at length during the onsite review. Only two activities had occurred specifically for V4. One was a paragraph stating that two V4 interviews would be done each month (though only one was done in the two month period July 2012 and August 2012). The other was a one page V4 Tool that appeared to be a first step towards trying to determine how to implement, and self-assess, V4. Overall, the monitoring team suggested that the DRC and URCs work collaboratively with other SSLCs and state office on this. Below, the six areas of this provision item are again presented, with some comments regarding MSSLC's status on each. <u>1. Records are accessible to staff, clinicians, and others</u> MSSLC was not yet self-assessing this. The monitoring team, however, observed that: • Direct support staff reported that the individual notebooks were easy to use and readily accessible. • Records were maintained in the home areas which clinicians had access to. • Records were available during psychiatry clinic and staff referred to them and reviewed documentation. • Habilitation therapists reported regular access to records. • The records for individuals with more complicated medical issues were reported to be more difficult to use because of the multiple volumes. As a result, sometimes some volumes were not transported to meetings or clinics and, therefore, all relevant information was not available. • Some dental progress notes noted problems with the accessibility of records. On 9/21/12, the dentist, "They only brought one of the active records. It took fifteen minutes to get the other necessary parts of the record." On 8/7/12, the dentist noted, "[Individual #510] came to his appointment, but no one brought his chart." • Current risk plans were not found in all individual notebooks for access by DSPs responsible for implementing plans. The Risk Action Plans should be included with the ISP and updated when the plan is revised. <u>2. Data are filed in the record timely and accurately</u> MSSLC was somewhat assessing this during the monthly audits, that is, when the URC indicated whether a document was in the record, up to date, and in the right place. The information from these reviews, however, should be used to satisfy this requirement, too.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The monitoring team's review of a sample of active records, the monthly URC audits, and the record clerk D-list audits indicated that some documents were not filed in a timely manner. • There were some missing medical reviews, ISPs, IPNs, assessments, etc. • Overall, medical data and reports appeared to be filed timely and accurately. • Habilitation documentation was predominately placed on separate consults and activity plans and filed in the habilitation therapy section of the active record rather than in the IPNs for ready access by all team members. <u>3. 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: • For most individuals observed throughout the MSSLC campus, data regarding their PBSPs were recorded right up to the time of the observation. • There were very few blank/missing entries in the 26 individuals' health status information, such as vital signs, weekly weight, etc. This was a significant improvement in performance from the prior review. • The only data collected for habilitation therapies programming, was related to program implementation rather than specific data on measurable outcomes from the goals and objectives. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> MSSLC appeared to be, but wasn't really, self-assessing this. The monitoring team observed: • The URC reviewed IPNs to check for integration of departments while doing the five monthly reviews. She recorded her findings on the active record audit tool and recorded her determination (yes/no) on the statewide self-monitoring tool. She reported that she made this determination to see if there were entries for the current month of the audit from each of the disciplines that was involved with the individual. Specific criteria, however, should be determined for this. • IPNs are more likely to be read and used if the notes are neat and legible. o Many physician entries were difficult to read. o Dr. Ellis generated electronic notes. This was very good. His notes were clear, easy to understand, and in SOAP format. o The physician assistant also made excellent notes. • The electronic QPMR form was the main mechanism of documentation by the psychiatrist. The psychiatrists also used the IPNs in making treatment decisions. • The IPNs failed to reveal that nurses consistently incorporated a review of the individual's history and/or prior illnesses and /or injuries as part of their evaluation and/or when they made care, treatment, and training decisions.	

#	Provision	Assessment of Status	Compliance
		• There were very few IPN entries made by habilitation therapies or the PNMT. IPN entries described actions taken by clinicians, but actual status updates, progress or intervention plans were not documented in the IPNs. • Some clinical disciplines, such as nutrition and respiratory did not appear to make IPN entries with any regularity. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> • The URC reported that two interviews were to be conducted each month, however, only one was reported during the two-month period of July 2012 through August 2012. The content of this interview was not submitted. Therefore, the monitoring team is unable to comment on it. o There was no summary of her interpretation of these interviews. • Physicians reported that individuals with more complicated medical conditions had multiple volumes in their active records. All volumes were usually not transported for clinics sometimes resulting in all information not being available. • The psychiatrists and the IDT referenced numerous documents from the unified record during the psychiatric clinics observed. The other disciplines inclusive of nursing summarized findings, such as laboratory work that was obtained from the unified record. • When a random sample of nurses were asked about how they used the individuals' record to make care/treatment/training decisions, they reported that during their quarterly and annual assessments and during the completion of audit/monitoring tools they reviewed the individuals' records and made decisions regarding whether or not individuals received care in accordance with the Settlement Agreement and Health Care Guidelines. • Habilitation therapies staff reported that the record was used for documentation, but as noted above, this was very limited. <u>6. 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</u> The monitoring team found the following: • During the ISP meeting for Individual #151, his active record volumes were present, but in a box in the back of the room. The RN case manager used the active record to look for information during the risk review discussion. When the record was accessed, the information filed in the record was helpful and informative to the IDT. It was unclear why the record was not used more often, especially since the RN case manager was not sufficiently informed/prepared to discuss the individual's health and health risks without it. • During the CLDP meeting for Individual #221, his active record volumes were	

#	Provision	Assessment of Status	Compliance
		present. The psychiatrist used the active record while making her report. • The psychiatric staff reported being overwhelmed with the "paperwork" duties of completing numerous tasks during the clinic without assistance (i.e., record reviews, typing the information provided and the results of clinic). • During the PNMT meeting there were no individual records available. • Although there was a greater focus on using clinical data to support risk ratings and the development of support plans, assessment information was not always readily available for teams to consider in their discussions.	

Recommendations:

1. Continue to work on the Appendix D requirements, such as legibility, signatures, entries, proper filing, and missing documents (though there had been much improvement since the last review) (V1).

2. Provide summarized data/documentation on annual refresher training for all staff (V1).

3. Finalize (a) how to deal with missing social histories and (b) placement of quarterly medical reviews (V1).

4. Have a plan to deal with (a) documents misfiled or not returned to the active record after being removed for copying or other supposedly temporary reasons, and (b) active record binders not being checked out and/or returned properly (V1).

5. Consider whether "Medical directions to staff" and/or "Signature of review of individual notebook" documents should be standard in all individual notebooks (V1).

6. The eight additional binders/logs should be considered to be part of the individual notebook and, therefore, receive the same review, auditing, and policy/procedure as do the individual notebooks (V1, V3).

7. In the master record, document efforts of the DRC/URC when a document that is not optional could not be obtained (V1).

8. Create a process for the implementation and training of relevant staff on state and facility-specific policies (V2).

9. Provide data on the number of staff who were supposed to be trained on every Settlement Agreement-related state and facility-specific policy, and the actual number of staff who were trained (V2).

10. Graph important recordkeeping outcomes as detailed in V3 and include in the facility's QA program (V3).

11. Obtain occasional interobserver agreement for the URC's V3 quality audits (V3).

12. 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
ADD	Attention Deficit Disorder
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
APAAP	Alkaline Phosphatase Anti Alkaline Phosphatase
APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
APES	Annual Psychological Evaluations

APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
AROM	Active Range of Motion
ASA	Aspirin
ASAP	As Soon As Possible
ASHA	American Speech and Hearing Association
AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Active Treatment Provider
AUD	Audiology
AV	Alleged Victim
BBS	Bilateral Breath Sounds
BC	Board Certified
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLE	Bilateral/Both Lower Extremities
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
BSPC	Behavior Support Plan Committee
BPRS	Brief Psychiatric Rating Scale
BTC	Behavior Therapy Committee
BUE	Bilateral/Both Upper Extremities
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CA	Campus Administrator
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System

CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CBZ	Carbamazepine
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
CEA	Carcinoembryonic antigen
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIN	Cervical Intraepithelial Neoplasia
CIP	Crisis Intervention Plan
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CM	Case Manager
CMA	Certified Medication Aide
CMax	Concentration Maximum
CME	Continuing Medical Education
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 Pharmacy Technician
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
DERST	Dental Education Rehearsal Simulation Training
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
DNP	Doctor of Nursing Practice
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
DSHS	Texas Department of State Health Services
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
ERC	Employee Reassignment Center
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FFAD	Face to Face Assessment Debriefing
FLACC	Face, Legs, Activity, Cry, Console-ability
FLP	Fasting Lipid Profile
FMLA	Family Medical Leave Act
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
GIFT	General Integrated Functional Training
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
IHCP	Integrated Health Care 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
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
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
LOI	Level of Involvement
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 Plan
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
ORIF	Open Reduction Internal Fixation
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
PA	Physician Assistant
P&T	Pharmacy and Therapeutics
PAD	Peripheral Artery Disease
PAI	Provision Action Information
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
PDR	Physicians Desk Reference
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
Pharm.D.	Doctorate, Pharmacy
Ph.D.	Doctor, Philosophy
PHE	Elevated levels of phenylalanine
PIC	Performance Improvement Council
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PKU	Phenylketonuria
PLTS	Platelets
PM	Physical Management
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PMRP	Protective Mechanical Restraint Plan
PMRQ	Psychiatric Medication Review Quarterly
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	Personal Skills Assessment
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSI	Preferences and Strength Inventory
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
RML	Right Middle Lobe
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
SIS	Second Injury Syndrome
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SOTP	Sex Offender Treatment Program
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
TCA	Texas Code Annotated
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
TSHA	Texas Speech and Hearing Association
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
UT	University of Texas
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VOD	Voice Output Device
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
WBC	White Blood Count
WFL	Within Functional Limits
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old